The VOLUNTARY HOSPITALS in GREAT BRITAIN

(EXCLUDING LONDON)

EIGHTH ANNUAL
Report for the Year
1926

By

R. H. P. ORDE,

Director of Hospital Services, Joint Council of The Grand Priory in the British Realm of the Venerable Order of the Hospital of St. John of Jerusalem and the British Red Cross Society.

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With a Foreword
by the
HON. SIR ARTHUR STANLEY
G.B.E., C.B., M.V.O.
Chairman of the Joint Council

19, BERKELEY STREET, W.1

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AND THE
BRITISH RED CROSS SOCIETY.

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By the Hon. Sir ARTHUR STANLEY, G.B.E., C.B., M.V.O.

Chairman of the Joint Council of the Order of St. John and the British Red Cross Society.

It is somewhat difficult in a Foreword which must necessarily be brief to deal with a Report such as this Eighth Annual Report of the Joint Council of the Order of St. John and the British Red Cross Society upon the Voluntary Hospitals in Great Britain, which contains so large an amount of interesting information and illuminating statistics. I can only call attention to one or two salient items.

It is satisfactory that in a year such as that under review, when conditions owing to strikes and other unrest were particularly adverse, the Voluntary Hospitals have held their own. No less than 67·28% have emerged with a credit balance on their maintenance accounts, and the surplus on all the hospitals for the year was over £250,000.

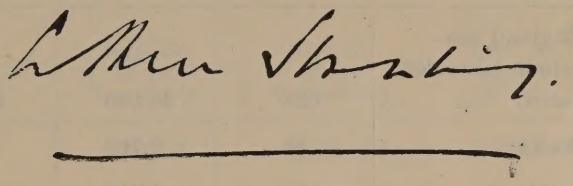
This result shows the wonderful hold that what is known as the " Voluntary System " has on the public mind and is a great encouragement to all workers in Voluntary Hospitals to persevere in their efforts to afford to the public a service which is obviously to its liking.

Another matter of great importance which is dealt with in this Report is the enormous increase of work and expenditure in which hospitals are involved by reason of accidents on the road. It is a fact in not a few places that the local hospital, which was sufficiently large and well equipped to deal with the hospital needs of its surrounding district, has been hopelessly crowded out by cases arriving in its wards by reason of accidents on the road. These patients for the most part do not belong to the district in which the hospital is situated, and have not contributed to its upkeep. Moreover, many of the sufferers are not in a position to pay for their treatment, the expense of which therefore falls upon the local supporters of the hospital. This is manifestly unfair, and some remedy must be found. If payment may be made by Insurance Companies in the case of insured people for medical treatment,—*i.e.*, for the doctor or surgeon—then surely the same payment should be forthcoming when the treatment is given in a hospital. It is satisfactory to know that this question, which is very urgent, is receiving the attention of the Hospital associations and of the Insurance Companies and the Royal Automobile Club.

The only other matter which I have space to notice appears in the Report under the head of Hospital Accommodation. As is well known, the Minister of Health has taken this matter up, and it is probable that some scheme of co-ordination between the Voluntary

Hospitals and the Poor Law Infirmaries will be brought forward during the coming year. Until we know more than we do now about the details of that scheme, it is useless to forecast the part which the Voluntary Hospitals will take in it, but it is safe to say that they are ready to do all in their power to meet the Minister's wishes so long as no element of compulsory representation is introduced into their Governing bodies. To insist upon Government or Municipal representation on the Boards or Committees of the Voluntary Hospitals would seriously endanger the voluntary system and might have the effect of drying up many of the sources from which their funds are now obtained. I would like to thank those Hospital Administrators who have so kindly added to the interest of the Report by expressing their views on this subject.

Mr. R. H. P. Orde, who is responsible for this Report and the interesting statistics it contains, deserves much credit for the way in which he has carried out his difficult and onerous task.



October, 1927.

INTRODUCTION.

I. SCOPE OF THE REPORT.

This Report reviews 98·56% of the Voluntary Hospital accommodation in Great Britain outside the London area. This is the highest percentage yet covered.

	Total Voluntary Hospital accommodation.		Reviewed in this Report.			
	No. of Hospitals.	No. of available beds.	No. of Hospitals.	Percentage of total.	No. of available beds.	Percentage of total.
England (excluding London area)	623	36,536	604	96·95%	36,179	99·02%
Wales	58	2,763	52	89·66%	2,613	94·57%
Scotland ...	110	8,216	99	90·00%	8,038	97·83%
Great Britain (excluding London area) ...	791	47,515	755	95·45%	46,830	98·56%

II. GENERAL SUMMARY OF THE FINANCES OF THE HOSPITALS REVIEWED IN 1926.

Hospital Finance for the year 1926 may be summarised thus :— **£7,916,816 was raised ; £7,666,596 was spent on maintenance and development ; leaving a surplus of £250,220.**

The number of Hospitals with a **credit balance** on their maintenance accounts was **67·28**% of the total.

SUMMARY OF INCOME AND EXPENDITURE FOR THE YEAR ENDING 31ST DECEMBER, 1926.

Ordinary Income	£ 5,612,690	Ordinary Expenditure	£ 5,909,699
Extraordinary Income	776,326	Extraordinary Expenditure... ...	21,720
Receipts for Capital purposes ...	1,527,800	Capital Expenditure...	1,735,177
		Surplus for the year	250,220
	£ 7,916,816		£ 7,916,816

In the year 1926, one of peculiarly adverse conditions, income fell by £222,404, and expenditure rose by £546,506. The hospitals were, therefore, in a worse financial position than in the year 1925 by £768,910.

Large figures tend to obscure a sense of reality. This sum of £768,910, large in itself, means neither more nor less than that each hospital bed was poorer in 1926 than in 1925 by £16 : 8s. : 4d. or less than

1/- per day. The amount would be even less if allowances were made for the increase in the volume of work done. The corollary to this would seem to be that the burden of clearing a hospital's deficits, although the actual sum may amount to several thousands of pounds, is but a small individual one if well distributed. There are few districts in which the proportion of the healthy to the sick is not so great as to make the individual contributions necessary to clear a hospital of debt, almost infinitesimal, especially in these days when the sick do a great deal either by way of Contributory Schemes or direct payments for treatment to help themselves.

III. PATIENTS TREATED DURING 1926.

Out of the 755 hospitals the finances of which are reviewed in this Report, one small hospital did not give details with regard to the number of patients treated during 1926. Consequently the following summary of work is not quite co-extensive with the summary of finance. The difference is, however, so small as to be practically negligible.

NUMBER OF PATIENTS TREATED.

	No. of hospitals giving details.	No. of available beds.	Total No. of new In-patients.	Total No. of new Out-patients.	Total No. of new patients.
England and Wales	656	38,792	569,480	2,351,585	2,921,065
Scotland	98	8,023	123,716	405,830	529,546
Total	754	46,815	693,196	2,757,415	3,450,611

The figures for the year 1926 confirm the estimate made in the 7th Report, that the yearly increase in the volume of work which the Voluntary Hospitals have to shoulder is approximately 40,000 in-patients and 150,000 out-patients.

IV. HOSPITAL ACCOMMODATION.

It is now more than two years since the Voluntary Hospitals Commission reported that the additional beds required for England and Wales numbered 10,000. The rate of increase in Voluntary Hospital beds during the period 1920-24, a period of activity, possibly a little above the normal, was about 1,000 beds per annum, and it was estimated that to provide the number which the Commission considered necessary within five years, some means of accelerating building operations would be necessary. No such means have yet been found, and a constantly increasing demand lays a heavier and heavier load upon accommodation that shows little signs of any acceleration in the rate of its growth.

It is possible, however, that so far as the Voluntary Hospitals are concerned the shortage of beds is not so great as the Commission reported. The last few years has placed a burden of traffic accidents upon them they were never intended to carry, and for which, if they are to do the work, they should receive payment sufficient to cover capital and maintenance costs. It is also possible that a serious attempt to define their sphere of work would give them further relief, and would throw responsibility for some of the shortage of beds on to other shoulders.

At the same time it cannot be doubted that a considerable shortage of beds still remains over to the debit of the Voluntary Hospitals, and there are no very evident signs of this being made good. Difficulties connected with site and with finance no doubt play a part, but more important than either may be the uncertainty that prevails both with regard to the present and to the future,

So far as the present is concerned there is a widespread feeling that much of the in-patient work which these hospitals are at present almost forced to undertake could be equally well performed in less expensively staffed and equipped institutions, and that in their out-patient departments the skill and energy of the specialists are largely expended upon those who ought to seek elsewhere the relief they may require. But until there is some agreement with regard to responsibility for the treatment of any displaced load, no hospital can make drastic alterations in its methods or close its doors to those who have come to rely upon its help. Indeed, its very efficiency and readiness to meet every call helps to create greater and greater demands and to postpone the consideration of those measures that can alone bring relief to its overworked staff and accommodation.

Again, the Voluntary Hospital does not pretend to provide continuously for more than the normal wants of its locality. It can, and indeed always does, rise to an emergency; the most recent and striking example was the aid which one of the oldest London hospitals rendered in a serious railway disaster in Kent. But a call of this kind is something totally different from the continuous toll which the advent of the motor now levies upon every hospital from the largest to the smallest.

At one hospital during the year 1926 an entire surgical ward of 25 beds was continuously occupied by patients who were suffering from the results of motor accidents. It is indeed the irony of fate that the service thus rendered to the community should lend colour to the view that the Voluntary Hospital is unable to keep pace with the demands that may legitimately be placed upon it. Five years ago these 25 beds were available for the treatment of the ordinary surgical complaints of patients in the district, and they would still be available had the facts connected with motor transport been effectively recognised.

It is indeed probable that no better places could be selected for the establishment of ambulance stations, equipped and staffed to deal with all motor casualties, than the Voluntary Hospitals, but it is not reasonable to expect them to use their existing accommodation or their normal sources of support for this purpose.

Still greater uncertainty exists with regard to the future. The relationship between the Voluntary hospital and the hospital provided by the Public Authorities still remains to be decided. There is doubt as to spheres of action. It may be difficult to define the exact function of the large, the medium, and the small hospital, and still more difficult the line that divides the Voluntary from the Municipal; but until some greater agreement is reached than exists at present, Committees of Management may well be excused from undertaking comprehensive schemes of development or large additions to their accommodation.

While too there is doubt as to the amount of new accommodation required, there is also considerable difference of opinion as to where and how any or all of it should be provided. There are those who think that the parent hospitals are rightly placed in the centres of population, and that new accommodation should be provided on their existing sites. There are those who think that parent hospital beds can be made to yield a larger output of patients by means of Homes of Recovery situated in the country. By others again the view is taken that hospitals should be in open spaces outside the cities.

Uncertainty and delay go hand in hand, and until the results of the experiments, which we are glad to see are being made, are available for the benefit of the hospital community generally, we cannot expect any very extensive hospital developments.

It is one of the chief merits of the Voluntary Hospital System that it enjoys complete freedom to experiment. Is there any good reason why this freedom should not be extended in such a way as to cover, in some selected area, an experiment in hospital organisation, accommodation and administration which the Voluntary Hospital and the Public Authorities might jointly carry out ?

It is possible that many of the difficulties which appear to exist at present are more imaginary than real, and that the solution of others would be more easily discovered by trial than by argument. One, however, of the real difficulties undoubtedly would be the maintenance, in the public eye, of an equality of status between the Voluntary and the Municipal Hospital. This, however, would largely

disappear were it to be found possible for the same staff, medical and surgical, to work in each. A community of control would also tend towards the minimising of differences. Whatever the defects of the Voluntary Hospital Committee may be, it is generally acknowledged that it has produced the best form of hospital up to the present. There is no reason to suppose that an extension of this method of government to cover both institutions would be any less satisfactory from the patients' point of view.

V. INSURANCE.

The subject of Insurance is generally treated with great delicacy in the hospital world. It is difficult to appreciate the cogency of any of the reasons that have been put forward for this attitude. There are few hospital Reports that do not draw attention to the increasing burden which motor traffic and a traditional obligation to admit and treat accidents at all hours of the day and night have forced upon them. Before the days of motor cars, when traffic accidents were less numerous, a hospital that admitted an injured patient, other than one without means, looked for and received donations in acknowledgment of the relief afforded. To-day, when accidents have been multiplied tenfold and when the injured are, with few exceptions, covered in one way or another by insurance, the hospital is dependent for any acknowledgment of the work it does upon casual generosity and is thought to have no claim at law against the Insurance Companies. There are those who think that no greater pressure should be exerted upon Insurance Companies than that of ordinary appeal, lest contributions of a voluntary character should be endangered, and there are others who accept the argument that if payments are demanded by the hospitals for work done in restoring the injured to health, the premium on policies will have to be raised, for a premium is based upon things as they are, and it is common knowledge that hospitals will cure for nothing that for which every other form of curative institution charges heavy fees.

Apart altogether from any question of fact, *i.e.*, whether voluntary contributions from the Insurance Companies would be endangered or whether they amount to any considerable sum of money, the former argument, except that it rests upon an even weaker foundation, differs in no respect from that which may still be found in certain districts, namely, that as hospitals are supported locally they must confine their custom to local tradesmen. There are none who will quarrel with such a preference, other things such as quality and price being equal, but that a hospital should buy its voluntary support by paying more for the goods it requires than is necessary is an untenable proposition. As a matter of fact, the idea that there is any real connection between voluntary support and local trading may be dismissed altogether. Although it is not possible to obtain figures covering the whole country, it is not without significance that in an area in which voluntary contributions amounted to £250,000, the total attributable to the great Insurance Companies was less than £200.

And with regard to the argument which has been somewhat naively accepted by many that were the hospitals to be paid for the work they do, the premium rates on policies would be forced up, it is only necessary to suggest that there would be little difficulty in anticipating the reply of, for example, the legal profession as a whole, should it be argued that premium rates might be lowered were lawyers to undertake insurance work for nothing. The truth is that insurance is one of the features of modern civilisation which enters upon a definite business basis into almost every phase of life, individual and corporate, except that which is spent as the result of a motor accident in a Voluntary Hospital. Is there a valid reason for this exception ? Every increase in the number of motor cars widens the field in which insurance policies may be effected, and adds to the burden which the hospitals have to bear. If it is the very efficiency of these hospitals which helps to keep the premium rate low, surely this is an additional reason why they should not be expected to do this work for nothing.

But it is not only in the matter of accidents due to motor cars that there is room for re-consideration of the terms of the relationship between the hospitals and the Insurance Companies. In one of the Northern Voluntary Hospitals there has been recently started a scheme of self-insurance under the Workmen's Compensation Act, based upon the experience of a period of ten years. The Committee of this Institution, after weighing up the risks involved, have felt justified in making an experiment that

promises a considerable saving of money. This experiment suggests a general pooling of hospital experience in the matter of Accident Insurance with a view either to the introduction of self-insurance schemes, or to the obtaining of more favourable rates from the Companies.

Similar arguments apply to the terms upon which Fire Insurance policies are effected. Whether hospitals are good or bad risks—and it is possible to assert that entries in the annual accounts of payments by Insurance Companies in respect of claims for damage by fire are rare—a Premium Rate must be based upon facts. Is there any reason why the accumulated experience of the past 25 years with regard to the relationship of premium paid to claims received, should not be available to the hospitals as a whole ? Whatever the figure may be, it is an easily ascertainable one, and should be in the possession of both parties to a business transaction.

In the early part of this year, several hospital Secretaries kindly ascertained these figures for their own institutions, and from them it was evident that a general return from the 800 Provincial hospitals would provide some justification for approaching the Insurance Companies with a view to obtaining better terms.

It is possible that hospitals are good risks and are helping to carry other forms of building which may be bad ones.

Insurance supplies a telling instance of the desirability of a Central Bureau *for the purpose of collecting data* to enable the hospitals as a whole to meet those with whom they negotiate on level terms.

VI. THE LARGE HOSPITAL.

This year a third division has been introduced into the A group of hospitals in England and Wales or those in which the number of beds is 100 or more. These three divisions are :—

14 Medical School hospitals.
23 Non-Medical School hospitals with 200 beds and over.
14 Non-Medical School hospitals with 150 to 199 beds.

Tables giving in some detail the figures both of work and finance relating to these hospitals will be found in the body of the Report.

It is interesting to attempt to arrive at some conclusions from a comparison of these figures. One of the broad facts that emerges from the tables is that the financial position of the Medical School hospitals is much more serious than that of those in either of the other two groups. Why ? They are certainly as deserving of public support ; they enjoy the same form of management ; in many cases their Administrators have gained experience in one or other of the hospitals in the non-Medical School group ; and they serve a wider, indeed in so far as they are the training schools for the doctors, a national, clientele. If they cost more to maintain, their claims on the public should bring them greater support.

Their higher rate of expenditure is indeed justified, for they work at a greater pressure and they deal with Out-patients on a larger scale. Moreover, as a group, they are the pioneers in Medicine and Surgery. It would be most unfair to attempt to minimise the progressive character of the work that is carried out in the Non-Medical School hospitals, but it is impossible to disregard the influence which a Medical School and the presence of students exerts, and it is generally agreed that this influence extends to expenditure in respect of both capital and maintenance.

But whatever their claims to support may be, the fact remains that whereas the 37 Non-Medical School hospitals were collectively more than able to meet their maintenance costs, the 14 Medical School hospitals fell short by almost £17 per occupied bed. The following figures are worthy of observation ; the Medical Schools hospitals actually receive less support than the Non-Medical School hospitals :—

INCOME AND EXPENDITURE ON MAINTENANCE ACCOUNT PER OCCUPIED BED.

	Income.	Expenditure.
Hospitals associated with Medical Schools	£ 172·64	£ 189·53
Hospitals without Medical Schools containing 200 or more beds ...	186·72	172·11
Ditto, 150 to 199 beds	176·89	157·16

It is possible that situation and size play a considerable part in the matter of support. The Medical School hospitals are situated in towns with an average population of 450,000. If we eliminate two in which the population is comparatively small, the average of the remainder is considerably over half-a-million. There is therefore, a less direct contact between the hospitals and all of those whom they serve, especially on the outskirts of their areas, than in the case of smaller institutions in less thickly populated districts. Two further facts are noteworthy in this connection :—

(1) In the Medical School group it is only in the two towns of small population already referred to that the hospitals have surpluses on their maintenance accounts.

(2) Four of the towns support two Medical School hospitals each, and in these there is the same division of local hospital patriotism that distinguishes the Metropolitan institutions from the majority of those in the Provinces, and makes the task of raising money in some respects more difficult.

The extent to which size of an institution enters into the problem is more difficult to determine. The average number of beds in each of the three divisions is :—

Medical School Group	359
Non-Medical—over 200 beds	260
Non-Medical—150 to 199 beds	162

It must be remembered too that the number of beds does not necessarily indicate completely the activity of an institution or the pressure at which it works. There are attached to every large hospital, numerous and costly adjuncts utilised often beyond their true capacity. The question does arise, and it is one of considerable importance at the present time : Is there not an optimum size of hospital, that is, one which is large enough to enjoy all those financial advantages that size alone can give (and which are mostly concerned with overhead charges) and yet not so large as to endanger the characteristics which differentiate a human activity from a machine ? There is some evidence that once this size is passed, efficiency can only be secured by a costly departmentalisation. Moreover, the larger the institution the more difficult to retain the human element without laying an intolerable burden upon the Committee of Management and Staff.

Some support is lent to this view by the following quotation from a paper read by the President of the Society of Incorporated Accountants and Auditors :—

> " There is a stage in every industry at which the size of the unit of economic production represents maximum efficiency. When this is reached, and the concern grows, other units are merely added, sometimes leading to an increase in the cost of production.
>
> " Therefore all mergers and amalgamations are not necessarily an advantage, either from an economic point of view or from considerations of public policy."

Indeed the comparatively small increase in the bed accommodation of the Medical School hospitals during the past decade suggests that those responsible for their management instinctively recognise the economic dangers attendant upon over-growth. When, however, an institution reaches its maximum economic size, and there exists a need for more beds, choice has to be made between the alternatives of finding a new site and launching another institution, or of resting content with measures of a palliative character such as extra beds in the wards, temporary annexes, discharge of patients at an earlier date, and so on. It is not to be wondered at that the financial difficulties of the present time, and the uncertainty that exists with regard to hospital policy have deterred Committees of Management from taking the former and bolder course.

It would seem, therefore, that from a financial point of view the ideal site for a Voluntary hospital is a town of such a size that an institution of approximately 300 beds can supply its wants. Such a hospital is large enough to secure any advantage that size can bring and can devote its energies, undisturbed by rivals, to securing all the support that its own people can give it. The problem of the provision of Voluntary hospitals for dense populations is only a part of the larger and more puzzling problem of the large city. The difficulty of area definition is, in many cases increased by the fact that the existing hospitals are not ideally placed. Wholesale transference of institutions, some of comparatively modern date, to new sites is a costly remedy. Again, the selection of a single hospital site outside the city boundaries is a step towards institutions much larger than those to which we have been accustomed.

Whatever advantage there may be in such a change it is at least open to doubt whether finance will turn out to be one. It may be that in hospital matters finance is not the final test, but when to finance is added the very doubtful blessing that size brings in its train, then it is time to consider whether arguments, largely taken from the industrial world, are really so cogent as is sometimes thought.

The provision of hospitals in over-grown towns is difficult, but obviously necessary. A single hospital site outside the city confines does not, however, exhaust the possibilities. A city is many sided, and its needs might be better served and at less cost by smaller institutions spaced on its boundaries.

VII. THE LADY ALMONER.

There still lingers in parts, not always remote, two almost entirely erroneous impressions regarding the Lady Almoner. These are the more unfortunate inasmuch as they partake of the nature of the half truth. She is regarded as an officer valuable, if at all, for her money-raising potentialities. Her services are supposed to be dispensed with in the case of those who join the Contributory Scheme. The Lady Almoner is probably the best possible person to assist in assessment, where assessment may be required, and a Contributory Scheme may help in the matter of the determination of status, but these are accidents of her calling, and do not touch upon essentials. It is as a giver and not as a receiver that she takes her place as a member of a hospital staff and her title of Almoner is more appropriate than has sometimes been held.

Sir Berkeley Moynihan's paper and the brief note which accompanies it, so kindly written by Miss Cummins, the Lady Almoner of St. Thomas's Hospital, will be given by all those who are responsible for the treatment and care of the patients, all the weight that must attach to the words of so distinguished a hospital surgeon and to those of a lady who is at the head of one of the most developed and progressive Almoners' Departments in the kingdom.

VIII. STATISTICS.

The value of statistics in Hospital Administrative work is known to every Hospital Administrator. They are essential to his control of expenditure and work, and, so far as his own institution is concerned, can be taken out on any basis that serves the object in view. As he is in possession of the details of all his departments, he is able to make allowances for any abnormal or disturbing factors affecting his results. His difficulties only begin when, in his efforts to obtain comparisons covering a wider field of experience, he includes figures referring to other institutions than his own.

For this purpose he is confined to tables prepared upon a time honoured bed basis. This basis was appropriate enough fifty years ago, when hospitals were less complex institutions, resembling one another in almost all respects except that some were larger than others.

As the defects of the bed basis are now well known, it may quite naturally be asked "Why is it still retained?" This question ought to be answered. Though defective, the bed basis, in the hands of those who have sufficient experience in hospital matters, is not entirely without value, and it

will always act as a ready reckoner for home consumption when comparing one period with another in an individual hospital.

Again, it is a basis that is somewhat deeply entrenched, and it will take time and patience to oust it. It is a distinct advance that its imperfections are recognised, and that there is now little danger of it being used without qualification in comparing hospital with hospital. Opinion, moreover, is gradually being built up in favour of improved statistics. Efforts too are being made to produce figures relating to departmental activities that lend themselves to comparison. This matter is referred to at greater length in Section 4, page 56.

Until, however, the volume of such departmental information increases considerably, it would hardly be wise to attempt so drastic a reform as the discarding of the bed basis altogether.

Lastly, there will always be imperfection whatever the basis of hospital statistics may be. There are limits beyond which their usefulness cannot be extended. They must always be interpreted with moderation and common sense. Even the Government Actuary in a Report on life tables based on the deaths recorded in the years 1920, 1921 and 1922, is compelled to issue a note of warning in his concluding paragraph, drawing attention to the danger of the average, or as he expresses it :—

> " In conclusion, it must be emphasised that the rates of mortality shown in the National tables are the results of the aggregation of data relating to a number of sections with widely-varying characteristics, and that the circumstances of any one particular area may not be at all accurately reflected at any point in the general experience to which it has contributed."

I beg to thank all those Hospital Superintendents and Secretaries throughout Great Britain for the courtesy with which they invariably respond to our requests for help.

I also desire to thank my colleague, Mr. A. E. Ceadel, F.S.S., for his invaluable assistance in the production of this Report.

R. H. Pave.

October, 1927.

The object which the Joint Council have in mind in issuing this Report (or Survey) is the presentation in as full detail as possible of the position of the Provincial Voluntary Hospitals in Great Britain with reference to certain special features which may be summarised thus :—

(*a*) The facilities available for treatment.

(*b*) The extent to which they are utilised.

(*c*) The annual cost of maintaining these facilities.

and (*d*) The sources and extent of the funds by which they are maintained.

Throughout this Report the Hospitals reviewed are grouped under the headings :—

Group A. Hospitals having **100 or more beds.**

Group B. Hospitals having **30 to 99 beds.**

Group C. Hospitals having **less than 30 beds.**

In addition, Tables of the details of the work and finances of the following special groups are given :—

Hospitals associated with **Medical Schools.**

Hospitals **without Medical Schools** containing **200 or more** available beds.

Ditto, **150 to 199** available beds.

Children's Hospitals.

Ear, Nose and Throat Hospitals.

Eye Hospitals.

Women's Hospitals.

VOLUME OF WORK DONE IN THE VOLUNTARY HOSPITALS IN ENGLAND AND WALES.

The relationships between the hospital groups A, B and C, with regard to the number of institutions in each, the accommodation provided and the work done in the In-Patient and Out-Patient departments can be most easily realised by means of a short table. It will be noticed that the B group hospitals are twice, and the C group three times as numerous as those in the A group, and that the number of beds in the three groups are almost in the reverse order.

Group.	Number of Institutions in each group are as	Number of beds in each group are as	Pressure as indicated by percentage of occupied beds.	Number of In-patients per available bed per year.	Number of Out-Patients per available bed per year.
A ...	1	4	85%	16	75
B ...	2	2	75%	14	45
C ...	3	1	62%	13	30

These relationships may be accepted as normal, the records extending over a sufficient number of years to safeguard against chance fluctuations.

TABLE 1.

NUMBER OF IN-PATIENTS AND OUT-PATIENTS TREATED AND PERCENTAGE OF AVAILABLE BEDS OCCUPIED.

Hospitals.	Year.	No. of Hospitals giving details.	No. of available beds.	Percentage of available beds occupied daily.	No. of New In-patients.	No. of New Out-patients.
Group A	1922	108	20,730	82·17%	260,066	1,273,792
	1923	115	22,071	82·75%	295,303	1,426,178
	1924	114	21,624	88·33%	317,871	1,545,380
	1925	116	22,281	84·50%	338,212	1,668,242
	1926	**118**	**22,832**	**84·95%**	**355,527**	**1,709,616**
Group B	1922	159	8,180	73·01%	95,575	342,957
	1923	183	9,116	72·68%	112,758	424,108
	1924	195	9,836	74·15%	124,515	438,644
	1925	197	10,141	73·80%	132,209	445,074
	1926	**204**	**10,736**	**75·36%**	**147,420**	**485,055**
Group C	1922	304	4,446	59·23%	47,395	110,589
	1923	322	4,766	62·79%	53,773	118,908
	1924	348	5,206	60·96%	60,413	152,746
	1925	339	5,197	62·26%	57,928	110,506
	1926	**334**	**5,224**	**62·12%**	**66,533**	**156,914**
Total	1922	571= 97% (*a*)	33,356= 98% (*b*)	—	403,036	1,727,338
	1923	620= 99% (*a*)	35,953= 99% (*b*)	—	461,834	1,969,194
	1924	657= 99% (*a*)	36,666= 99% (*b*)	—	502,799	2,136,770
	1925	652= 99% (*a*)	37,619= 99% (*b*)	—	528,349	2,223,822
	1926	**656=100% (*a*)**	**38,792=100% (*b*)**	—	**569,480**	**2,351,585**

(*a*) Percentage of Hospitals reviewed.
(*b*) Percentage of beds in Hospitals reviewed.

Table 2 is a development of the corresponding Table in previous Reports. It is doubtful whether it would serve any useful purpose to attempt at present to carry grouping further. It will be noticed that Auxiliary accommodation is shown separately and that the C group has been sub-divided in order that a better picture of the pure type of Cottage Hospital may be presented.

Auxiliary (*i.e.*, Recovery and Convalescent) beds form rather less than 10% of the accommodation in the 37 hospitals of over 200 beds, they are almost non-existent in the 70 hospitals with from 100 to 200 beds. These hospitals probably find that it is cheaper to make use of independent auxiliary accommodation than to establish their own.

For practical purposes the appropriate proportion of auxiliary to parent hospital beds is an important figure to ascertain. If one in ten is sufficient then there does not seem to be much room for expansion in this direction except in the group of hospitals under 200 beds in size. There is, however, evidence that in hospitals in which surgical work bulks largely, a very much higher number than one auxiliary bed to 10 parent hospital beds can be kept constantly occupied. We refer to this again later.

The large amount of Out-patient work done in the 11 hospitals other than Cottage Hospitals in the C group, and in the Special Hospitals as a whole is noticeable.

TABLE 2.

NUMBER OF PATIENTS TREATED IN GENERAL AND SPECIAL HOSPITALS DURING 1926 SHOWN SEPARATELY.

Hospitals.	No. of Hospitals giving details.	No. of available beds.	No. of New In-patients.	No. of New Out-patients.
General Hospitals—				
Group A				
Medical School Hospitals ..	14	5,023	91,123	603,897
		* 404	4,843	
Hospitals without Medical Schools containing—				
200 or more beds	23	5,970	94,428	422,418
		* 510	7,981	
150 to 199 beds	14	2,276	34,578	144,282
		* 57	671	
100 to 149 beds	56	6,516	91,806	396,266
		* 70	757	
Group B	146	7,427	100,365	263,045
		* 54	614	
Group C				
Cottage Hospitals	290	4,410	52,953	57,401
Other than Cottage Hospitals	11	214	3,279	30,993
Totals of General Hospitals	**554**	**31,836**	**468,532**	**1,918,302**
		* **1,095**	**14,866**	
Special Hospitals—				
Group A	11	1,962	28,824	142,753
		* 44	516	
Group B	58	3,225	46,176	222,010
		* 30	265	
Group C	33	600	10,301	68,520
Totals of Special Hospitals	**102**	**5,787**	**85,301**	**433,283**
		* **74**	**781**	

* Auxiliary Hospitals and Convalescent Homes under the control of the Hospitals.

TABLE 3.

NUMBER OF SURGICAL OPERATIONS (UNDER GENERAL ANÆSTHETIC).

Hospitals.	Year.	No. of Hospitals giving details.	No. of available beds and percentage of total reviewed.	No. of operations.
Group A	1922	101	19,503=93%	215,935
	1923	105	19,872=90%	238,594
	1924	109	20,739=96%	268,834
	1925	113	21,691=97%	293,175
	1926	**113**	**22,030=96%**	**316,212**
Group B	1922	135	7,118=84%	76,974
	1923	163	8,327=90%	93,703
	1924	178	9,005=90%	104,963
	1925	178	9,263=91%	110,020
	1926	**185**	**9,859=92%**	**125,252**
Group C	1922	194	3,006=66%	28,939
	1923	259	3,934=82%	35,608
	1924	318	4,851=92%	46,213
	1925	302	4,687=90%	48,290
	1926	**293**	**4,698=90%**	**50,731**
Total	1922	430=73·25%*	29,627=87·22%	321,848
	1923	527=84·46%*	32,133=89·07%	367,905
	1924	605=91·39%*	34,595=93·93%	420,010
	1925	593=90·69%*	35,641=94·55%	451,485
	1926	**591=90·09%***	**36,587=94·32%**	**492,195**

* Percentage of Hospitals reviewed.

Table 3. The amount of operative work, even in the C group is surprising. On a bed basis the figures for the three groups are :—

Group.	Number of Operations per available bed.
A	14·3
B	12·7
C	10·8

If we compare the amount of the operative work done in the Provincial hospitals during 1926 with that done during 1921, it would appear that there has been an increase of something like 25%.

Tables 4, 5 and 6. We still continue the tabulation of the work done in the X-ray, the Electro-therapeutic and Massage Departments of those hospitals which give sufficient detail in their Annual Reports for the purpose. We do so because we have faith. After all there are very few hospitals in which the Administrator does not watch closely the growth of departmental work as recorded daily, and from his periodic summaries obtain information upon which to advise his Committee. It only requires the adoption of some common form to enable a comprehensive summary of the departmental work of the hospitals as a whole to be prepared. It would not be difficult to find instances of the disadvantage of not being able to give chapter and verse when matters of general hospital interest have been the subject of discussion and when tendencies in one or the other direction may be the deciding factors in arriving at any useful conclusions. The records of work of the hospitals as a whole may be of just as vital importance to their collective well-being as are the individual records to the well-being of the individual institution. It is therefore of importance that they should be available..

TABLE 4.

X-RAY DEPARTMENT.

Hospitals.	Year.	No. of Hospitals giving details and percentage of total reviewed.	*Total No. of patients treated in those Hospitals.	No. of Radiographs.	No. of Screen Exams.	No. of Treatments.
Group A	1922	54=49·54%	786,861	100,630	26,495	50,745
	1923	59=51·30%	1,004,206	143,539	45,889	67,068
	1924	51=44·74%	859,860	146,078	31,573	54,664
	1925	57=49·14%	960,180	192,540	26,912	61,727
	1926	**58=49·15%**	**1,128,467**	**234,125**	**30,648**	**66,555**
Group B	1922	29=17·68%	63,679	9,889	4,867	11,488
	1923	43=23·37%	132,379	15,229	4,963	8,449
	1924	44=22·34%	137,184	20,268	4,232	4,704
	1925	46=23·23%	151,380	30,682	3,857	4,685
	1926	**44=21·57%**	**148,115**	**31,351**	**2,554**	**16,942**

* These patient figures (including both in-and out-patients) do *not* refer to the work in the department.

TABLE 5.

ELECTRO-THERAPEUTIC DEPARTMENT.

Hospitals.	Year.	No. of Hospitals giving details, and percentage of total reviewed.	*Total patients treated at those Hospitals.	No. of Treatments given.
Group A	1922	33=30·27%	465,986	311,365
	1923	31=26·96%	396,710	216,889
	1924	28=24·56%	451,781	264.200
	1925	32=27·59%	509,614	366,225
	1926	**38=32·20%**	**660,535**	**341,377**
Group B	1922	14= 8·54%	36,870	55,175
	1923	17= 9·24%	59,624	56,908
	1924	10= 5·08%	34,568	16,027
	1925	12= 6·06%	36.085	17,286
	1926	**16= 7·84%**	**46,073**	**29,933**

* These patient figures (including both in-and out-patients) do *not* refer to the work in the department.

TABLE 6.

MASSAGE DEPARTMENT.

Hospitals.	Year.	No. of Hospitals giving details, and percentage of total reviewed.	*Total patients treated at those Hospitals.	No. of Treatments given.
Group A	1922	46=42·20%	697,728	546,606
	1923	39=33·91%	650,657	479,496
	1924	38=33·33%	729,136	490,222
	1925	47=40·52%	754,641	583,031
	1926	**45=38·14%**	**897,202**	**669,900**
Group B	1922	17=10·37%	44,627	100,419
	1923	23=12·50%	73,200	68,453
	1924	21=10·66%	67,160	52,014
	1925	25=12.63%	86,806	75,758
	1926	**37=18·14%**	**134,972**	**107,703**

* These patient figures (including both in-and out-patients) do *not* refer to the work in the department.

Tables 7, 8, 9. We have added this year Table 9 which gives, under letters, a group of 14 hospitals in which the accommodation ranges from 150 to 199 beds. We hope next year to add another Table so as to complete the list of hospitals in the A group. We trust that this Table will make the Report more interesting to a larger number of hospitals, each of which is, of course, easily able to identify its own letter. Indeed we can see no harm whatever in publishing the names of the hospitals in full, but such a publication is entirely dependent upon the consent of each hospital. The only purpose which the Joint Council have in view is to supply the figures in the manner most likely to be of real use to the Provincial hospitals.

The figures of the three groups may be summarised as follows :—

Group.	No. of Hospitals.	No. of available beds.	Occupation.			Work per Occupied Bed.		
			Highest Average Occupation.	Lowest Average Occupation.	No. of Hospitals with over 85% Occupation.	In-Patients.	Out-Patients	Operations.
Medical School Hps.	14	5,023	103%	81%	13	20·1	133	20
Hospitals having 200 or more beds ...	23	5,970	93	78	14	18·2	81	17
Hospitals having from 150 to 199 beds ...	14	2,276	111	62	8	17·6	73	18

The average length of stay of patients covered approximately the same range in each group, viz. :—

	Highest.	Lowest.
Medical School Hospitals	24.7	12.8
Hospitals having 200 or more available beds	25.5	15.5
Hospitals having from 150 to 199 available beds	26.9	12.7

The extremely short stay of 12.7 days in a hospital in the third group was brought about by auxiliary accommodation.

If we turn to the individual groups we find in the Medical School hospitals considerable growth everywhere except in In-Patient accommodation. In this Group of hospitals In-Patient accommodation in 1922 was 4,465 beds ; in 1926 it was 5,023, and most of this increase was due to the admission of hospital N to Medical School rank. It is not surprising, therefore, that the percentage occupation continues to rise, and the passage of patients through the beds to grow more rapid. In one of these hospitals as many as 28 patients were treated during the year in each bed, and in another 24. An average length of stay of 21 days, which gives a passage through the beds of 17 patients a year, used to be considered a reasonable rate for a General Hospital. Altered methods of treatment and Homes of Recovery influence the length of stay of a patient in a parent hospital bed, but we are inclined to think that in this group in which 11 out of the 14 hospitals show diminishing periods, the most important factor is the pressure of patients awaiting admission. We have alluded elsewhere to some of the possible reasons why these hospitals continue to work their beds at such high pressure. It must not, however, be assumed that because the number of beds available in 1926 was actually two less than in 1925, there has been no expansion in these hospitals. Interesting references to developments in the Out-Patient Department, in research or in administrative arrangements, are found in the Reports of nearly every hospital. Indeed it would be utterly wrong to conclude from the figures of bed accommodation that these hospitals were standing still. The truth is that, in spite of a continuous In-patient pressure that has for some considerable time remained at emergency point, these

TABLE 7.

SURVEY OF THE WORK DONE IN THE 14 HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN ENGLAND AND WALES.

1	2	3	4	5	6	7	8	9
Hospital.	Year.	No. of available beds.	Average No. of beds occupied daily.	Percentage of available beds. occupied.	No. of new In-patients.	Average length of stay per In-patient (days).	No. of new Out-patients.	No. of Surgical Operations.
A	1922	324	273·59	84·44	4,477	22·36	26,821	4,233
	1923	324	280·56	86·59	4,780	21·41	29,116	4,056
	1924	324	277·12	85·53	5,069	19·98	31,191	4,004
	1925	328	281·93	85·95	5,556	18·50	32,476	4,631
	1926	**337**	**272·72**	**80·93**	**5,799**	**17·22**	**33,544**	**5,252**
B	1922	218	181·85	83·41	2,428	27·49	16,638	1,758
	1923	220	189·50	86·14	2,488	27·98	18,966	2,173
	1924	220	199·88	90·85	2,675	27·29	21,922	2,301
	1925	221	200·91	90·91	2,802	26.19	25,362	2,741
	1926	**221**	**200·62**	**90·78**	**2,998**	**24·38**	**25,733**	**3,199**
C	1922	370	297·00	80·27	5,773	19·00	42,041	5,421
	1923	370	314·00	84·86	6,153	18·62	47,696	6,317
	1924	369	318·00	86·18	6,868	16·90	51,777	7,085
	1925	371	323·00	87·06	6,751	17·50	55,384	8,257
	1926	**369**	**326·00**	**88·35**	**6,970**	**17·00**	**59,858**	**8,012**
D	1922	224	180·80	80·71	3,602	18·30	20,224	3,652
	1923	224	181·70	81·12	3,437	19·20	23,547	3,751
	1924	224	185·80	82·95	3,675	20·10	26,053	4,302
	1925	224	192·20	85·80	3,414	20·60	27,328	4,257
	1926	**224**	**192·96**	**86·14**	**3,539**	**19·85**	**25,672**	**4,080**
E	1922	381	341·00	89·50	5,487	—	34,367	4,068
	1923	363	351·00	96·69	5,445	25·00	38,859	2,609
	1924	363	341·00	93·94	5,498	22·00	41,967	1,972
	1925	476	376·00	78·99	5,459	25·30	45,592	2,536
	1926	**443**	**407·00**	**91·87**	**6,237**	**24·70**	**42,940**	**8,027**
F	1922	236	210·00	88·98	3,115	23·25	32,721	3,323
	1923	316	234·00	74·05	3,683	23·52	47,926	3,836
	1924	316	274·00	86·71	4,286	23·07	39,181	4,431
	1925	316	269·00	85·13	4,139	23·58	44,977	4,291
	1926	**316**	**275·00**	**87·03**	**4,140**	**24·00**	**44,706**	**4,829**
G	1922	350	275·60	78·74	5,403	19·70	44,899	2,436
	1923	350	287·70	82·20	5,766	17·30	49,102	2,604
	1924	343	300·00	87·46	6,120	17·10	56,690	6,572
	1925	350	310·00	88·57	6,727	16·10	60,226	7,587
	1926	**370**	**319·30**	**86·30**	**6,916**	**16·12**	**60,253**	**7,458**
H	1922	268	239·15	89·24	3,966	22·01	22,157	2,108
	1923	268	241·88	90·25	4,212	20·94	25,088	3,422
	1924	268	245·25	91·51	4,649	19·37	27,597	2,694
	1925	268	244·17	91·11	4,673	19·00	30,420	2,646
	1926	**268**	**240·88**	**89·88**	**4,697**	**19·43**	**28,884**	**2,665**
I	1922	614	524·46	85·42	11,044	17·33	46,623	8,049
	1923	614	541·00	88·11	10,696	17·62	46,596	8,698
	1924	618	539·00	87·22	10,814	17·95	42,348	8,953
	1925	618	543·00	87·86	11,047	17·68	45,062	9,053
	1926	**618**	**542·00**	**87·70**	**11,052**	**17·99**	**46,718**	**9,657**
J	1922	546	445·00	81·50	9,785	15·90	41,857	9,470
	1923	542	461·00	85·06	10,778	15·05	47,536	10,552
	1924	542	467·00	86·16	11,248	14·60	50,777	11,403
	1925	542	477·00	88·01	12,083	13·90	62,739	12,788
	1926	**542**	**471·00**	**86·90**	**12,688**	**12·80**	**60,313**	**12,925**
K	1922	534	525·40	98·39	11,411	16·80	93,406	11,755
	1923	534	537·40	100·64	12,159	16·10	105,426	12,256
	1924	534	539·00	100·94	12,865	15·30	110,525	12,436
	1925	538	535·00	99·44	13,281	14·70	116,252	13,082
	1926	**542**	**556·00**	**102·58**	**13,942**	**15·30**	**124,629**	**14,257**

TABLE 7.—*continued.*

1	2	3	4	5	6	7	8	9
Hospital.	Year.	No. of available beds.	Average No. of beds occupied daily.	Percentage of available beds occupied.	No. of new In-patients.	Average length of stay per In-patient (days).	No. of new Out-patients.	No. of Surgical Operations.
L	1922	210	176·00	83·81	2,984	22·00	7,733	2,594
	1923	205	169·00	82·44	3,092	20·40	9,971	2,178
	1924	205	172·00	83·90	3,339	17·45	9,521	2,446
	1925	205	191·00	93·17	3,561	19·65	9,705	2,538
	1926	**205**	**187·00**	**91·22**	**3,600**	**18·92**	**9,885**	**2,900**
M	1922	190	168·00	88·42	2,231	27·46	8,987	2,376
	1923	190	179·00	94·21	2,374	27·77	10,166	2,596
	1924	190	174·00	91·58	2,748	23·06	10,701	2,866
	1925	190	177·00	93·16	2,980	21·70	11,896	2,943
	1926	**190**	**169·00**	**88·95**	**3,001**	**20·36**	**12,249**	**2,963**
*N	1923	341	318·60	93·43	5,016	24·33	23,476	4,619
	1924	341	323·80	94·96	5,445	22·80	24,769	4,738
	1925	378	340·80	90·16	5,720	22·60	26,647	4,816
	1926	**378**	**354·60**	**93·81**	**5,544**	**24·30**	**28,513**	**5,352**
Totals ..	1922	4,465	3,837·85	85·95	71,706	—	438,474	61,243
	1923	4,861	4,286·34	88·18	80,079	—	523,501	69,667
	1924	4,857	4,355·85	89·68	85,299	—	545,019	76,203
	1925	5,025	4,461·01	88·78	88,193	—	594,066	82,166
	1926	**5,023**	**4,514·08**	**89·87**	**91,123**	—	**603,897**	**91,576**

* Recognised as a Medical School during 1923.

NOTE.—Other Tables relating to the above Hospitals are Nos. 16, 24, 30 and 35

hospitals have yet found energy and money to develop and improve their methods of treatment and their organisation.

In the group of 23 hospitals without Medical Schools having 200 or more beds, the available accommodation has increased, but only to the extent of 6% in three years as compared with 4·5% in the Medical School group in four years. The pressure on these hospitals is not quite so great as in the Medical School group. If we take the treatment of 20 In-patients and 133 Out-patients per occupied bed per year as indicating the average activity of the Medical School group, then we find that only one of the non-Medical School hospitals reaches both of these figures, although four others reach the In-patient figure. At the same time, an average occupation of almost 87% means that there is little to choose between the activities of these hospitals and their Medical School fellows. The suggestions that we have already made as to the reason why accommodation has not kept pace with demand in the Medical School group, are possibly equally applicable to these hospitals also.

The new group of 14 hospitals without Medical Schools, and having accommodation of from 150 to 199 beds is, in its way, a very representative one. Ten of these hospitals serve busy inland manufacturing towns, three serve large seaports and four are situated in cathedral cities. Two of the towns have populations of over 200,000 inhabitants, and more than half exceed 100,000. The smallest has only 23,000 inhabitants. All, of course, serve a rural population in addition to an urban. If we compare the figures of these hospitals with those of the two preceding groups, we find little diminution in the demand made upon the beds. Six out of the 14 have an average occupation of over 90%. One hospital indeed achieved the remarkable figure of 111%, and the average for the group exceeds 86%. One hospital in this group, by means of auxiliary accommodation raised the yearly rate of passage of patients through each of its beds to as large a number as 29.

The figures of this hospital are interesting, they are :—

	No. of beds available.	Average No. occupied.	Average No. of days resident.
Parent Hospital	153	135	12·77
Auxiliary A	37	36	24·88
Auxiliary B	43	35	19·04

It appears that where surgical work bulks largely, a parent hospital of 150 beds can provide patients for 80 auxiliary beds.

TABLE 8.

SURVEY OF THE WORK DONE IN THE GENERAL HOSPITALS WITHOUT MEDICAL SCHOOLS, CONTAINING 200 OR MORE AVAILABLE BEDS.

1	2	3	4	5	6	7	8	9
Hospital	Year.	No. of available beds.	Average No.of beds occupied daily.	Percentage of available beds occupied.	No. of new In-patients.	Average length of stay per In-patient (days).	No. of new Out-patients.	No. of Surgical Operations
O	1923	192	175·50	91·41	2,425	26·38	4,261	2,028
	1924	202	163·93	81·15	2,467	24·38	4,917	2,072
	1925	200	176·77	88·38	2,605	24·76	5,679	2,221
	1926	**200**	**168·79**	**84·39**	**2,718**	**22·65**	**6,150**	**2,418**
P	1923	215	181·50	84·42	3,119	21·27	8,526	2,094
	1924	215	189·50	88·14	3,416	20·40	9,664	2,791
	1925	215	185·04	86·07	3,579	18·80	10,166	2,479
	1926	**215**	**190·95**	**88·81**	**3,695**	**18·86**	**11,070**	**3,067**
Q	1923	225	157·38	69·95	2,486	23.89	10,300	1,206
	1924	225	194·84	86·60	3,094	23·09	11,995	1,554
	1925	225	187·23	83.31	3,097	22·18	13,019	1,739
	1926	**225**	**195·00**	**86·67**	**3,402**	**20·86**	**15,703**	**1,881**
R	1923	201	159·62	79·41	2,033	29·25	6,626	1,691
	1924	206	166·39	80·77	2,191	27·84	8,287	1,910
	1925	206	168·02	81·56	2,348	26·11	8,211	2,084
	1926	**206**	**161·66**	**78·48**	**2,614**	**22·40**	**9,911**	**2,236**
S	1923	216	157·50	72·92	3,151	18·22	16,454	3,609
	1924	247	198·60	80·40	3,458	21·00	17,835	3,464
	1925	307	222·00	72·31	3,998	20·50	19,453	3,533
	1926	**307**	**256·30**	**83·49**	**4,432**	**21·00**	**18,680**	**3,869**
T	1923	320	289·00	90·31	4,350	24·00	21,050	3,414
	1924	320	289·00	90·31	4,806	22·00	22,843	5,897
	1925	330	295·00	89·39	5,126	21·00	24,974	5,785
	1926	**330**	**303·00**	**91·82**	**5,439**	**20·00**	**25,267**	**6,122**
U	1923	223	206·00	92·38	2,155	32·00	5,517	1,676
	1924	223	195·00	87·44	2,277	30·00	6,320	1,797
	1925	223	199·00	89·24	2,510	28·50	6,458	1,886
	1926	**223**	**202·00**	**90·58**	**3,043**	**25·50**	**6,670**	**2,350**
V	1923	296	248·60	83·99	3,806	22·46	29,688	—
	1924	297	243·80	82·09	3,904	21·45	30,826	3,983
	1925	297	274·14	92·30	3,712	23·02	33,388	2,132
	1926	**297**	**271·66**	**91·47**	**3,892**	**21·81**	**32,536**	**4,089**
W	1923	300	219·29	73·10	2,655	29·38	11,710	2,465
	*1924	Report covers a period of nineteen months.						
	1925	250	218·04	87·22	3,436	23·33	12,162	4,000
	1926	**250**	**231·37**	**92·55**	**3,770**	**22·10**	**14,710**	**4,139**
X	1923	305	281·20	92·20	4,641	22·50	23,409	6,348
	1924	410	321·00	78·29	5,186	22·60	26,907	7,018
	1925	400	324·50	81·12	5,793	20·50	27,852	8,056
	1926	**386**	**334·50**	**86·66**	**6,169**	**19·80**	**30,352**	**8,454**
Y	1923	225	199·00	88·44	3,488	20·77	17,196	2,846
	1924	215	202·00	93·95	3,611	20·58	19,306	2,823
	1925	225	201·00	89·33	3,799	19·25	18,933	3,713
	1926	**225**	**202·00**	**89·78**	**3,979**	**18·38**	**20,153**	**4,092**
Z	1923	260	197·64	76·02	3,717	20·54	36,630	2,775
	1924	260	203·51	78·28	3,519	21·09	27,486	2,779
	1925	260	212·54	81·75	3,981	19·61	29,536	3,003
	1926	**260**	**219·73**	**84·51**	**4,087**	**19·59**	**28,718**	**2,655**
AA	1923	231	190·00	82·25	2,539	27·00	11,593	1,315
	1924	233	185·00	79·40	2,795	22·00	12,484	2,418
	1925	221	173·00	78·28	2,855	22·00	12,896	2,505
	1926	**225**	**185·00**	**82·22**	**3,355**	**20·00**	**13,770**	**1,606**

TABLE 8.—*continued.*

1	2	3	4	5	6	7	8	9
Hospital	Year.	No. of available beds.	Average No. of beds occupied daily.	Percentage of available beds occupied.	No. of new In-patients.	Average length of stay per In-patient (days).	No. of new Out-patients.	No. of Surgical Operations
BB	1923	285	250·00	87·72	3,311	27·30	11,840	2,365
	1924	285	248·00	87·02	4,051	22·40	9,220	4,091
	1925	285	262·00	91·93	4,055	23·60	11,875	2,893
	1926	**293**	**266·50**	**90·96**	**4,603**	**21·00**	**11,956**	**3,279**
CC	1923	310	264·00	85·16	4,777	20·10	27,324	2,915
	1924	317	267·00	84·23	4,860	20·00	27,038	2,162
	1925	317	272·70	86·03	5,026	19·80	31,459	2,917
	1926	**317**	**273·40**	**86·25**	**5,332**	**18·30**	**31,515**	**3,077**
DD	1923	188	160·00	85·11	2,831	19·00	9,454	2,915
	1924	200	171·00	85·50	3,139	18·30	12,853	3,600
	1925	211	192·00	91·00	3,606	18·00	15,372	4,012
	1926	**220**	**189·00**	**85·91**	**3,815**	**17·30**	**16,888**	**4,792**
EE	1923	213	169·50	79·58	2,700	21·50	8,169	2,870
	1924	213	176·87	83·04	2,825	21·50	8,750	3,244
	1925	215	185·90	86·47	3,029	21·16	9,017	3,583
	1926	**218**	**181·33**	**83·18**	**3,069**	**20·38**	**8,951**	**3,482**
FF	1923	304	280·00	92·11	4,406	23·25	30,216	9,604
	1924	304	275·00	90·46	4,770	20·99	30,134	5,628
	1925	304	275·00	90·46	4,403	22·74	28,794	5,921
	1926	**304**	**277·00**	**91·12**	**4,745**	**21·06**	**31,469**	**5,615**
GG	1923	310	291·38	93·99	5,519	19·30	12,374	3,806
	1924	310	294·42	94·97	5,880	18·29	12,528	4,041
	1925	310	287·35	92·69	6,122	17·04	13,641	3,857
	1926	**310**	**277·95**	**89·66**	**6,542**	**15·55**	**13,417**	**4,609**
HH	1923	262	209·50	79·96	3,913	19·50	15,471	—[1]
	1924	262	219·29	83·70	4,127	19·70	17,896	3,663
	1925	293	222·19	75·83	4,124	20·15	19,730	3,500
	1926	**316**	**260·97**	**82·59**	**4,653**	**20·47**	**22,927**	**3,902**
II	1923	210	182·76	87·03	3,393	18·86	23,498	3,780
	1924	210	179·46	85·46	3,389	18·37	27,667	3,721
	1925	210	180·30	85·86	3,675	17·14	25,651	3,986
	1926	**210**	**190·69**	**90·80**	**3,839**	**17·31**	**27,335**	**4,081**
JJ	1923	166	147·32	88·75	2,607	20·62	7,994	2,674
	1924	160	133·40	83·37	2,687	18·17	10,926	2,760
	1925	225	138·22	61·43	2,821	18·13	11,507	3,086
	1926	**225**	**182·24**	**81·00**	**3,613**	**18·44**	**14,592**	**4,281**
KK	1923	176	130·50	74·15	2,390	18·90	6,581	1,524
	1924	176	147·50	83·81	2,608	20·70	7,214	1,706
	1925	200	146·70	73·35	3,188	17·00	8,821	2,056
	1926	**208**	**166·30**	**79·95**	**3,622**	**16·70**	**9,678**	**2,177**
Totals ..	1923	5,633	4,747·19	84·27	76,412	—	355,881	63,920
	*1924	5,490	4,664·51	84·96	79,060	—	363,096	73,122
	1925	5,929	4,998·64	84·31	86,888	—	398,594	78,947
	1926	**5,970**	**5,187·34**	**86·89**	**94,428**	—	**422,418**	**86,273**

NOTE.—Other Tables relating to the above Hospitals are Nos. 17, 25, 31 and 36.

TABLE 9.

SURVEY OF THE WORK DONE IN THE GENERAL HOSPITALS WITHOUT MEDICAL SCHOOLS, CONTAINING FROM 150 TO 199 AVAILABLE BEDS.

1	2	3	4	5	6	7	8	9
Hospital.	Year.	No. of available beds.	Average No. of beds occupied daily.	Percentage of available beds occupied.	No. of new In-patients.	Average length of stay per In-patient (days).	No. of new Out-patients.	No. of Surgical Operations.
LL	1924	156	104·97	67·29	1,799	21·38	15,326	728
	1925	156	105·50	67·63	1,768	21·93	15,605	724
	1926	**156**	**96·55**	**61·86**	**1,666**	**21·16**	**15,119**	**765**
MM	1924	152	158·80	104·47	2,853	20·22	8,102	3,017
	1925	152	165·78	109·07	3,077	19·84	8,159	3,378
	1926	**152**	**169·27**	**111·36**	**3,281**	**18·83**	**10,318**	**3,692**
NN	1924	150	135·00	90·00	3,990	12·38	11,561	3,737
	1925	153	132·00	86·27	4,056	11·87	12,203	3,812
	1926	**153**	**135·00**	**88·24**	**3,859**	**12·77**	**12,025**	**3,418**
OO	1924	190	147·97	77·88	2,072	26·55	9,007	3,624
	1925	190	178·43	93·91	2,410	27·26	10,245	4,166
	1926	**190**	**178·35**	**93·87**	**2,727**	**23·91**	**10,674**	**4,573**
PP	1924	143	137·28	96·00	2,294	21·93	10,796	2,110
	1925	154	140·00	90·91	2,362	20·51	11,031	2,359
	1926	**165**	**140·30**	**85·03**	**2,475**	**20·71**	**11,477**	**2,354**
QQ	1924	121	90·00	74·38	1,573	20·00	7,233	1,068
	1925	150	120·00	80·00	1,785	28·00	7,679	1,209
	1926	**150**	**111·00**	**74·00**	**1,820**	**21·00**	**7,863**	**1,250**
RR	1924	181	143·20	79·12	2,118	24·90	3,841	1,951
	1925	185	162·01	87.57	2,177	27·46	4,863	2,094
	1926	**185**	**169·36**	**91·55**	**2,283**	**26·94**	**5,659**	**2,388**
SS	1924	166	153·68	92·58	2,874	19·59	16,765	3,162
	1925	166	159·93	96·34	3,038	19·39	17,995	3,336
	1926	**184**	**168·16**	**91·39**	**3,087**	**19·84**	**18,820**	**3,449**
TT	1924	164	127·20	77·87	1,760	26·50	4,266	1,248
	1925	153	131·30	85·82	1,824	26·10	4,910	1,166
	1926	**153**	**122·50**	**80·07**	**1,996**	**22·20**	**5,386**	**1,392**
UU	1924	157	143·29	91·27	2,711	19·44	9,054	2,562
	1925	159	150·01	94·35	3,058	17·90	9,703	2,712
	1926	**160**	**152·43**	**95·27**	**2.924**	**18·98**	**10,016**	**2,524**
VV	1924	158	147·00	93·04	2,002	26·50	3,789	1,364
	1925	158	142·00	89·87	2,095	24·50	4,362	1,592
	1926	**158**	**121·00**	**76·58**	**1,825**	**24·00**	**5,999**	**1,630**
WW.. ..	1924	178	141·00	79·21	2,221	23·00	13,287	1,697
	1925	174	157·00	90·23	2,670	21·00	15,356	1,877
	1926	**170**	**163·00**	**95·88**	**2,372**	**25·00**	**14,611**	**1,839**
XX	1924	130	110·89	85·30	1,752	23·05	4,191	1,795
	1925	130	113·93	87·64	1,729	23·92	4,377	1,762
	1926	**150**	**114·97**	**76·65**	**1,969**	**21·16**	**5,462**	**2,206**
YY	1924	145	113·00	77·93	1,942	21·40	9,488	—
	1925	145	117·00	80·69	2,133	20·00	10,711	2,628
	1926	**150**	**119·00**	**79·33**	**2,294**	**20·00**	**10,853**	**4,765**
Totals ..	1924	2,191	1,853·28	84.59	31,961	—	126,706	28,063
	1925	2,225	1,974·89	88·76	34,182	—	137,199	32,815
	1926	**2,276**	**1,960·89**	**86·16**	**34,578**	—	**144,282**	**36,245**

NOTE.—Other Tables relating to the above Hospitals are Nos. 18, 26, 32 and 37.

Table 10 gives four groups of Special Hospitals classified according to the nature of their work. Out-patient work bulks rather largely in two of these groups. Operative work, especially in the Children's hospitals, appears to be heavy. Before any really satisfactory group figures can be produced it would be necessary to have some rather more detailed information regarding the nature of the work done. No doubt a large number of comparatively minor operations are included in the totals.

TABLE 10.

SURVEY OF THE WORK DONE IN CERTAIN GROUPS OF SPECIAL HOSPITALS.

Hospitals.	No. of Hps.	No. of available beds.	Average No. of beds occupied daily.	Percentage of available beds. occupied.	No. of new In-patients.	No. of new Out-patients.	No. of Surgical Operations.
Children's Hospital	18	1668	1386·29	83·11%	23,859	114,894	26,378
Ear, Nose, and Throat Hospitals ..	7	173	118·24	68·35%	6,023	29,411	9,366
Eye Hospitals ..	19	783	524·68	67·01%	10,284	162,952	13,053
Women's Hospitals	8	412	364·39	88·44%	8,510	13,342	7,189

NOTE.—Other Tables relating to the above Hospitals are Nos. 19, 33 and 38.

SECTION 2.

INCOME AND EXPENDITURE ON MAINTENANCE ACCOUNT.

Reference has frequently been made in these Reports to the misleading character of the terms " Ordinary " and " Extraordinary " Income as used in hospital finance. A hospital may, at the end of the year, find that its Ordinary Income falls short of its Ordinary Expenditure by several thousands of pounds, and the public may acquire the impression that on the year's working this sum represents an adverse balance, whereas in reality, in addition to its Ordinary Income it has received money more than sufficient to cover the deficit, and utilisable for maintenance purposes.

In order that a more accurate view of the financial position of the Provincial Voluntary Hospitals may be obtained, new Tables have this year been introduced, numbered 11 to 19 inclusive, prepared in such a way as to enable a definite answer to be given to the important question, viz. :—Did the income received during the year suffice to meet the expenditure incurred on maintaining the hospitals for that period? In previous Reports it has never been possible to state definitely the number of hospitals that would be found to be paying their way if all so called " Extraordinary " Income (available for maintenance purposes) and " Extraordinary " Expenditure were taken into account. This year the figures have been analysed so that the matter is no longer one of doubt.

These new Tables have an additional advantage in that they can now be read in conjunction with the corresponding Tables of " General Fund Income and Expenditure " in the Statistical Report of King Edward's Hospital Fund for London, relating to the London Hospitals. The terms " General Fund Income and Expenditure " and " Income and Expenditure on Maintenance Account " both represent items which, under the Revised Uniform System of Hospital Accounts, should be dealt with in the Income and Expenditure Account, and both show the cost of maintenance and income received available to meet that cost, as distinct from all Capital transactions.

Table 11 shows that not only did the hospitals as a whole pay their way during 1926, but that each group had surpluses on their maintenance accounts. It supplies the answer to those who question the ability of the Voluntary Hospitals to find money to carry out their work. It is true that in each group there are hospitals that have been very hardly hit financially. It is also true that in a Voluntary system the surplus of one hospital cannot be transferred to meet the deficit of another. On the other hand, taking the hospitals as a whole, we have no knowledge of any year in which the income available for maintenance purposes failed to meet the expenditure, nor have we ever heard of a hospital for which there was real need in the locality, passing out of existence because of continued failures to make both ends meet. In our Report for the year 1923, special attention was given to this point and the financial position of 34 individual hospitals whose Total Incomes during that year had failed to meet their Total Expenditures was examined. It was found that over a four-year period 19 had large surpluses, and that the adverse balances of the remainder were due more to capital expenditure on considerable extensions than to ordinary maintenance costs, and amounted to such sums as would give no anxiety to their treasurers or to their bankers. The fact that there was an actual surplus of £285,869 in a year like 1926, when, if ever, an adverse balance might have been expected, is a very striking fact.

Reference to Tables numbered 12 and 21 shows what effect the inclusion of " Extraordinary " income and expenditure has upon the financial position of the hospitals. In 1926 it raised the number of hospitals having surpluses from 354 to 437, or from 54% to 67% of the total.

A comparison between Tables 11 and 44 shows that Extraordinary Income is made up almost entirely of legacies left unconditionally to the hospitals. To this source of income a hospital can over a period of years look to receive approximately 1/10th of the cost of its yearly maintenance. The effect of industrial disputes on legacies given to hospitals is not likely to be felt until some years after

their occurrence and, as might be expected, the amount received from this source in 1926 was normal, that is, about £13 per bed. On the other hand, the effect upon both Ordinary Income and Ordinary Expenditure was immediate and marked.

It is also interesting to observe from the figures in Table 11 that the relationship of Extraordinary to Ordinary Income during 1926 was approximately the same in each group, viz. :— one-ninth, and that on the Expenditure side although the proportion is a much smaller one, it is approximately the same in the small as in the large hospitals. This similarity tends to show the stability of the sources of hospital support, and that in the Hospital World both the so-called " Extraordinary " income and expenditure lend themselves to intelligent budgetting, almost as surely as that which is called " Ordinary."

It is not possible to observe, unfortunately, this symmetry in the figures showing surplus. If the Group A hospitals were as well off as the Group C, they would be the happy possessors of a surplus of over £500,000 instead of only £63,000.

Tables 12 and 13.—If we examine on the basis of the available bed the income of those hospitals which have surpluses on their maintenance accounts, and compare it with that of those which have deficits, we find that the figures as are follows :—

Hospitals with surpluses on their maintenance accounts.	Hospitals.	Number of available beds.	Income per available bed.	
			Ordinary.	Extraordinary.
Group A	68	11,639	£ 137·4	£ 18·0
,, B	131	6,503	121·2	20·5
,, C	238	3,739	123·8	16·7
Hospitals with deficits on their maintenance accounts.				
Group A	50	11,193	121·2	8·5
,, B	73	4,233	98·9	3·4
,, C	96	1,485	91·2	1·0

As at first sight, there is no very definite connection between extraordinary and ordinary income, the former being, if not entirely of a windfall character, at any rate much more fortuitous than the latter, it is a little surprising that the hospitals with deficits in each group should receive an amount so markedly below the sums received by hospitals with surpluses in this respect. Windfalls are, speaking generally, less dependent upon locality and temporary conditions of industry than subscriptions and contributory funds. The figures, however, do suggest a closer connection between these two sources of income than might at first sight be supposed. Without going so far as to say that the figures supply a concrete example of the principle that Providence helps those who help themselves, we do think that they suggest that legacies, for example, are not altogether a matter of chance. It is certainly the fact that but for legacies the Scottish hospitals would be unable to meet their maintenance costs, and it is certainly also a fact that the leaving of a legacy to a hospital is much more a habit North of the Tweed than it is further South. There are few devices in the art of appealing for money that are not known to the average hospital Secretary, but if the habit of legacy leaving can be, and it certainly has been, successfully inculcated in Scotland, it would appear that there is here a field for appeal ingenuity that has not been worked as completely as possible. In other words, legacies respond to organised effort much more than might be thought, and this fact appears to be better understood in certain areas than in others.

It will be noted that while the 437 hospitals with credit balances received practically 1/7th of their income from free legacies, the 219 with adverse balances received only 1/17th.

TABLE 11.

INCOME AND EXPENDITURE ON MAINTENACE ACCOUNT.

Hospitals.	No. of Hpls.	Income.			Expenditure.			Surplus.
		Ordinary.	Extra-ordinary.	Total.	Ordinary.	Extra-ordinary.	Total.	
Group A	118	£ 2,957,375	£ 304,908	£ 3,262,283	£ 3,186,491	£ 12,610	£ 3,199,101	£ 63,182
Group B	204	1,206,877	147,994	1,354,871	1,226,335	6,263	1,232,598	122,273
Group C	334	598,505	64,236	662,741	560,193	2,134	562,327	100,414
Total	**656**	**£ 4,762,757**	**£ 517,138**	**£ 5,279,895**	**£ 4,973,019**	**£ 21,007**	**£ 4,994,026**	**£ 285,869**

TABLE 12.

HOSPITALS HAVING AN EXCESS OF **INCOME OVER EXPENDITURE** ON MAINTENANCE ACCOUNT.

Hospitals.	No. of Hospitals.	Income.			Expenditure.			Surplus.
		Ordinary.	Extra-ordinary.	Total Income available for maintenance.	Ordinary.	Extra-ordinary.	Total Expenditure on maintenance.	
Group A	68 (58%)	£ 1,600,202	£ 209,530	£ 1,809,732	£ 1,553,928	£ 6,018	£ 1,559,946	£ 249,786
Group B	131 (64%)	788,145	133,607	921,752	728,210	3,627	731,837	189,915
Group C	238 (71%)	462,989	62,700	525,689	405,021	862	405,883	119,806
Total ..	**437 (67%)**	**£ 2,851,336**	**£ 405,837**	**£ 3,257,173**	**£ 2,687,159**	**£ 10,507**	**£ 2,697,666**	**£ 559,507**

TABLE 13.

HOSPITALS HAVING AN EXCESS OF **EXPENDITURE OVER INCOME** ON MAINTENANCE ACCOUNT.

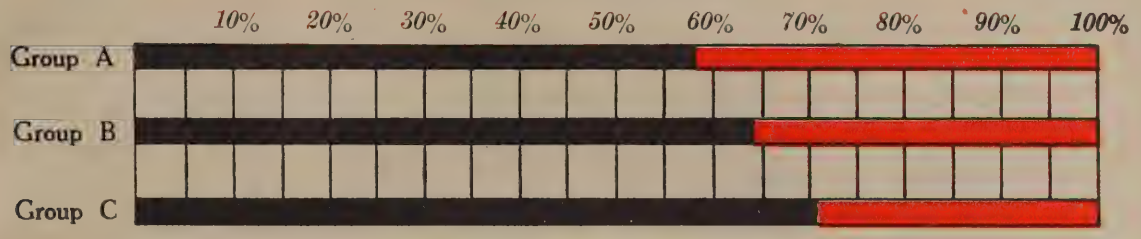
Hospitals.	No. of Hospitals.	Income.			Expenditure.			Deficit.
		Ordinary.	Extra-ordinary.	Total Income available for maintenance.	Ordinary.	Extra-ordinary.	Total Expenditure on maintenance.	
Group A ..	50 (42%)	£ 1,357,173	£ 95,378	£ 1,452,551	£ 1,632,563	£ 6,592	£ 1,639,155	£ 186,604
Group B ..	73 (36%)	418,732	14,387	433,119	498,125	2,636	500,761	67,642
Group C ..	96 (29%)	135,516	1,536	137,052	155,172	1,272	156,444	19,392
Total ..	**219 (33%)**	**£ 1,911,421**	**£ 111,301**	**£ 2,022,722**	**£ 2,285,860**	**£ 10,500**	**£ 2,296,360**	**£ 273,638**

INCOME AND EXPENDITURE ON MAINTENANCE ACCOUNT.

PERCENTAGE OF HOSPITALS HAVING AN EXCESS OF :—

INCOME OVER EXPENDITURE . . . . . Shown in Black.

EXPENDITURE OVER INCOME . . . . . Shown in Red.



Illustrating Tables 12 and 13.

TABLE 14.

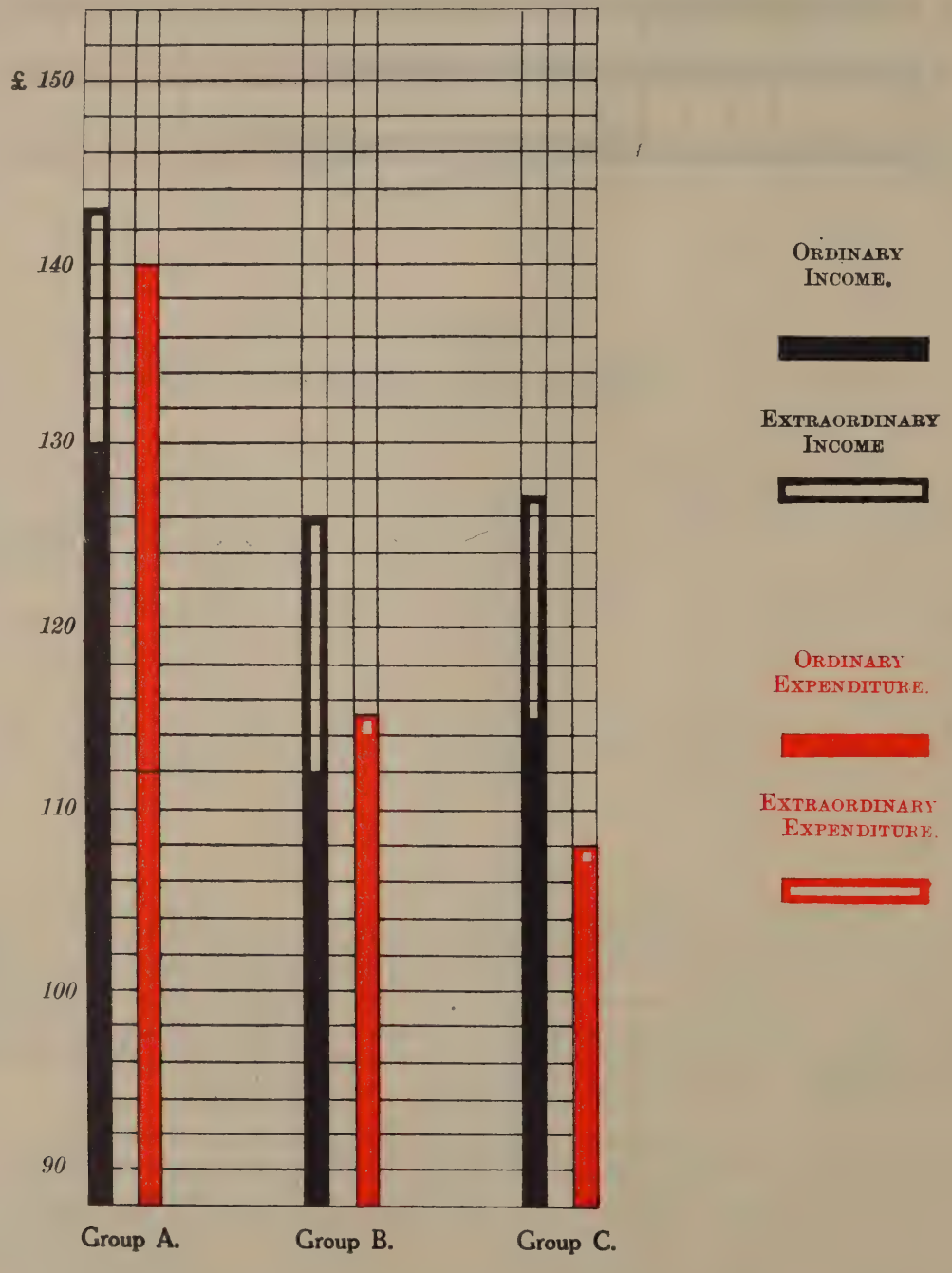
INCOME AND EXPENDITURE ON MAINTENANCE ACCOUNT PER AVAILABLE BED.

Hospitals.	No. of Hospitals.	No. of available beds.	Per *available* bed.		
			Income.	Expenditure.	Surplus.
Group A	118	22,832	£ 143	£ 140	£ 3
Group B	204	10,736	126	115	11
Group C	334	5,224	127	108	19
Total	**656**	**38,792**	**£ 136**	**£ 129**	**£ 7**

Table 15 presents as true a financial picture of each group of hospitals as the data available allow. It may, for instance, be noted that the C General hospitals are here divided into two groups of which one contains the Cottage hospitals pure and simple, and the other covers 11 hospitals which either restrict their services to certain classes of the community, or which, although primarily Dispensaries, possess beds. As the hospitals in the C group are commonly regarded as Cottage hospitals, the separation of these 11 hospitals from the Cottage type is an obvious advantage.

It will be noticed too that the figures of the Parent hospitals are separated from those of their Recovery or Convalescent adjuncts. Owing to differences in the financial relationships between the Parent and the Auxiliary Institutions it has been necessary to eliminate all transfers and set out the figures in the way shown in the table ; but it should be explained that the deficit of £62 for example, against the Auxiliary hospitals of the Medical School group is a charge upon the income of the Parent hospitals. Most of the Auxiliaries possess some independent income, but it is seldom sufficient to meet their expenditure, and a transfer from the funds of the Parent hospital becomes necessary. In order, therefore, to arrive at a true understanding of the financial position of any group, the combined figures of the Hospitals and their Auxiliaries, which are shown in ordinary type, should be taken.

INCOME AND EXPENDITURE ON MAINTENANCE ACCOUNT PER AVAILABLE BED.



Illustrating Tables 14 and 23.

TABLE 15.

INCOME AND EXPENDITURE ON MAINTENANCE ACCOUNT OF GENERAL AND SPECIAL HOSPITALS SHOWN SEPARATELY.

Hospitals.	No. of Hpls.	No. of available beds.	Income. Ordinary.	Income. Extra-ordinary.	Income. Total Income available for Maintenance.	Expenditure. Ordinary.	Expenditure. Extra-ordinary.	Expenditure. Total Expenditure on Maintenance.	Per *available* bed. † Income.	Per *available* bed. † Expenditure.	Per *available* bed. † Deficit.	Per *available* bed. † Surplus.
General Hospitals—												
Group A												
Medical School Hospitals	*14*	*5,023*	£ *708,127*	£ *71,183*	£ *779,310*	£ *855,025*	£ *508*	£ *855,533*	£ *155*	£ *170*	£ *15*	—
		* *404*	*9,487*	—	*9,487*	*34,529*	—	*34,529*	*23*	*85*	*62*	—
	14	5,427	717,614	71,183	788,797	889,554	508	890,062	145	164	19	—
Hospitals without Medical Schools containing:—												
200 or more available beds ..	*23*	*5,970*	*860,371*	*108,186*	*968,557*	*890,966*	*1,845*	*892,811*	*162*	*150*	—	£ *12*
		* *510*	*24,161*	*120*	*24,281*	*32,350*	*1,280*	*33,630*	*48*	*66*	*18*	—
	23	6,480	884,532	108,306	992,838	923,316	3,125	926,441	153	143	—	10
150 to 199 available beds ..	*14*	*2,276*	*317,893*	*28,977*	*346,870*	*302,992*	*5,174*	*308,166*	*152*	*135*	—	*17*
		* *57*	—	—	—	*4,181*	—	*4,181*	—	*73*	*73*	—
	14	2,333	317,893	28,977	346,870	307,173	5,174	312,347	149	134	—	15
100 to 149 available beds ..	*56*	*6,516*	*831,357*	*60,797*	*892,154*	*847,182*	*2,949*	*850,131*	*137*	*130*	—	*7*
		* *70*	*1,919*	*1,181*	*3,100*	*4,177*	—	*4,177*	*44*	*60*	*16*	—
	56	6,586	833,276	61,978	895,254	851,359	2,949	854,308	136	130	—	6
Group B	*146*	*7,427*	*832,755*	*78,801*	*911,556*	*835,532*	*3,442*	*838,974*	*123*	*113*	—	*10*
		* *54*	*669*	—	*669*	*2,970*	—	*2,970*	*12*	*55*	*43*	—
	146	7,481	833,424	78,801	912,225	838,502	3,442	841,944	122	113	—	9
Group C												
Cottage Hospitals	290	4,410	467,174	43,376	510,550	435,590	1,975	437,565	116	99	—	17
Other than Cottage Hospitals ..	11	214	49,181	5,745	54,926	41,687	70	41,757	257	195	—	62
Totals of General Hospitals	*554*	*31,836*	£ *4,066,858*	£ *397,065*	£ *4,463,923*	£ *4,208,974*	£ *15,963*	£ *4,224,937*	£ *140*	£ *133*	—	£ *7*
		* *1,095*	*36,236*	*1,301*	*37,537*	*78,207*	*1,280*	*79,487*	*34*	*73*	£ *39*	—
	554	**32,931**	**4,103,094**	**398,366**	**4,501,460**	**4,287,181**	**17,243**	**4,304,424**	**137**	**131**	—	**6**
Special Hospitals—												
Group A	*11*	*1,962*	£ *202,798*	£ *34,464*	£ *237,262*	£ *212,071*	£ *854*	£ *212,925*	£ *121*	£ *109*	—	£ *12*
		* *44*	*1,262*	—	*1,262*	*3,018*	—	*3,018*	*29*	*69*	£ *40*	—
	11	* 2,006	204,060	34,464	238,524	215,089	854	215,943	119	108	—	11
Group B	*58*	*3,225*	*373,329*	*69,193*	*442,522*	*386,982*	*2,821*	*389,803*	*137*	*121*	—	*16*
		* *30*	*124*	—	*124*	*851*	—	*851*	*4*	*28*	*24*	—
	58	3,255	373,453	69,193	442,646	387,833	2,821	390,654	136	120	—	16
Group C	33	600	82,150	15,115	97,265	82,916	89	83,005	162	138	—	24
Totals of Special Hospitals	*102*	*5,787*	£ *658,277*	£ *118,772*	£ *777,049*	£ *681,969*	£ *3,764*	£ *685,733*	£ *134*	£ *118*	—	£ *16*
		* *74*	*1,386*	—	*1,386*	*3,869*	—	*3,869*	*19*	*52*	£ *33*	—
	102	**5,861**	**659,663**	**118,772**	**778,435**	**685,838**	**3,764**	**689,602**	**133**	**118**	—	**15**

† Calculated to the nearest £.

* Figures relating to Auxiliary Hospitals and Convalescent Homes under the control of the Hospitals.

Reference to Tables 16 and 24 shows how severely the adverse conditions of the year 1926 affected the Medical School hospitals. At the end of 1925 there was on *Ordinary* Income a deficit per occupied bed of rather less than £10 and the trend of the figures over the preceding years, viz. :—

1920	...	...	...	£63	deficit	on	*Ordinary*	Income per occupied bed.
1921	...	...	...	£53	,,	,,	,,	,,
1922	...	...	...	£27	,,	,,	,,	,,
1923	...	...	...	£10	,,	,,	,,	,,
1924	...	...	...	£25	,,	,,	,,	,,
1925	...	...	...	£10	,,	,,	,,	,,

justified the hope that these hospitals were over their more serious financial troubles. The industrial disputes, however, of 1926 speedily dispelled any chance of income balancing expenditure, and the year ended with a deficit on *Ordinary* Income of nearly £33 per occupied bed. This deficit, even after including on both income and expenditure sides all "extraordinary" items, was not reduced to a lower figure than £16·89. Only two out of the 14 hospitals raised enough money during the year to clear the year's expenses. It is surprising that they did so, for they had to face conditions that sapped their resources at the root, that raised the price of much they had to buy and that certainly did not tend to lighten the burden of work they had to do.

Table 17 must be read in conjunction with Table 25. In this group of 23 hospitals only four failed to pay their way. This comparatively happy state of affairs was largely brought about by the extraordinary income which converted nine of the 13 deficits on ordinary income and expenditure into surpluses. It may be noted that the extraordinary income in this group was somewhat above the average, being just over one-eighth of that received as ordinary.

Table 18.—These 14 hospitals of 150 to 199 beds appear as a group for the first time in this Report. Although the amount of extraordinary income which they received was below the average, being not more than one-eleventh of the ordinary, it was sufficient to convert five out of the seven deficits on ordinary income shown in Table 26 into surpluses.

The deficit of one of the two hospitals in this group which failed to pay their way was infinitesimal.

Table 19 deals with a certain number of Special Hospitals. We have omitted those which are of a composite character, *e.g.*, those devoted to the treatment of Women and Children. So far as an opinion can be formed from the basis of income per occupied bed, these Special Hospitals appear to form a more prosperous body than the General Hospitals. Each group has a surplus on the year's working. One of the features of the figures is the proportion of extraordinary income to ordinary. Taking the 52 hospitals as a whole, extraordinary income forms more than one-sixth of the total. In the Ear, Nose, and Throat Hospitals and in the Eye Hospitals it amounts to approximately one quarter.

Table 20.—Although this Table gives only a partial view of the income raised for maintenance purposes, yet as extraordinary income bears year by year so steady a relationship to the total, the figures are not without value as showing trend. Taking the totals it will be seen that although the conditions that prevailed in 1926 were particularly bad, yet the hospitals came well through the ordeal. Their Ordinary Income fell short of the year 1925, a peak year, by no more than £38,085, or approximately £1 per available bed. It is important to bear in mind that the same cause that interfered with their sources of support also automatically increased their expenditure. This increase amounted to £299,542, or approximately £7 14s. 0d. per available bed, but how much of this is attributable to adverse causes and how much to natural expansion it is impossible to say. The deficit of £210,262 is very largely confined to the A group of hospitals. It is larger than any deficit since the year 1921.

Tables 20 to 26 prepared upon the old basis under which " Extraordinary " Income and Expenditure are excluded, are retained temporarily, but their publication will be discontinued so soon as the Tables based upon the cost of maintenance cover a period sufficiently long to provide data for the purpose of comparing year with year.

TABLE 16.

INCOME AND EXPENDITURE ON MAINTENANCE ACCOUNT OF THE 14 HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN ENGLAND AND WALES.

Hospital.	Income.			Expenditure.			Per *occupied* bed.			
	Ordinary.	Extra-ordinary.	Total.	Ordinary.	Extra-ordinary.	Total.	Income.	Expenditure.	Deficit.	Surplus.
A ..	£ 41,216	£ 2,406	£ 43,622	£ 48,762	—	£ 48,762	£ 159·95	£ 178·80	£ 18·85	—
B ..	27,293	1,005	28,298	37,641	£ 5	37,646	141·05	187·65	46·60	—
C ..	67,451	4,077	71,528	75,579	16	75,595	219·41	231·87	12·46	—
D ..	32,982	2,868	35,850	37,219	283	37,502	185·79	194·35	8.56	—
E ..	52,264	6,729	58,993	63,183	5	63,178	144·95	155·21	10·26	—
F ..	41,033	4,760	45,793	47,552	5	47,557	166·52	172·93	6·41	—
G ..	44,739	9,030	53,769	66,987	152	67,139	168·40	210·27	41·87	—
H ..	29,728	7,283	37,011	43,439	—	43,439	153·65	180·33	26·68	—
I ..	86,794	11,823	98,617	108,991	12	109,003	181·94	201·11	19·17	—
J ..	79,997	10,131	90,128	98,197	—	98,197	191·35	208·49	17·14	—
K ..	82,146	4,148	86,294	93,942	11	93,953	155·21	168·98	13·77	—
L ..	41,076	2,029	43,105	41,432	—	41,432	230·51	221·56	—	£ 8·95
M ..	25,764	1,020	26,784	26,044	—	26,044	158·49	154·11	—	4·38
N ..	55,644	3,874	59,518	66,067	19	66,086	167·85	186·37	18·52	—
Total ..	**£ 708,127**	**£ 71,183**	**£ 779,310**	**£ 855,025**	**£ 508**	**£ 855,533**	**£ 172·64**	**£ 189·53**	**£ 16·89**	—

NOTE.—Other Tables relating to the above Hospitals are Nos. 7, 24, 30, and 35.

TABLE 17.

INCOME AND EXPENDITURE ON MAINTENANCE ACCOUNT OF GENERAL HOSPITALS WITHOUT MEDICAL SCHOOLS CONTAINING 200 OR MORE AVAILABLE BEDS.

Hospital.	Income.			Expenditure.			Per *occupied* bed.			
	Ordinary.	Extra-ordinary.	Total.	Ordinary.	Extra-ordinary.	Total.	Income.	Expenditure.	Deficit	Surplus.
O	£ 25,303	£ 90	£ 25,393	£ 28,753	£ 44	£ 28,797	£ 150·44	£ 170·61	£ 20·17	—
P ..	34,199	1,356	35,555	35,091	52	35,143	186·20	184·04	—	£ 2·16
Q ..	33,571	6,656	40,227	38,115	—	38,115	206·29	195·46	—	10·83
R ..	21,909	2,956	24,865	23,968	133	24,101	153·81	149·08	—	4·73
S ..	40,188	1,271	41,459	37,096	42	37,138	161·76	144·90	—	16·86
T ..	45,832	3,266	49,098	45,458	—	45,458	162·04	150·03	—	12·01
U ..	22,856	16,323	39,179	26,072	—	26,072	193·96	129·07	—	64·89
V ..	41,390	9,316	50,706	37,158	268	37,426	186·65	137·77	—	48·88
W ..	47,621	282	47,903	42,890	—	42,890	207·04	185·37	—	21·67
X ..	70,705	5,741	76,446	71,344	130	71,474	228·54	213·67	—	14·87
Y ..	22,145	798	22,943	30,987	7	30,994	113·58	153·44	39·86	—
Z ..	40,410	22,302	62,712	45,060	—	45,060	285·40	205·07	—	80·33
AA ..	33,879	1,097	34,976	34,753	—	34,753	189·06	187·85	—	1·21
BB ..	43,488	1,676	45,164	46,301	—	46,301	169·47	173·74	4·27	—
CC ..	50,492	4,522	55,014	50,843	—	50,843	201·22	185·97	—	15·25
DD ..	40,719	10	40,729	26,655	78	26,733	215·50	141·44	—	74·06
EE ..	41,100	210	41,310	33,899	201	34,100	227·82	188·05	—	39·77
FF ..	42,560	10,650	53,210	51,466	—	51,466	192·09	185·80	—	6·29
GG ..	29,014	16,033	45,047	40,543	50	40,593	162·07	146·04	—	16·03
HH ..	39,540	2,284	41,824	53,554	137	53,691	160·26	205·74	45·48	—
II ..	33,742	633	34,375	33,097	373	33,470	180·27	175·52	—	4·75
JJ ..	33,812	552	34,364	32,530	—	32,530	188·56	178·50	—	10·06
KK ..	25,896	162	26,058	25,333	330	25,663	156·69	154·32	—	2·37
Total ..	**£ 860,371**	**£ 108,186**	**£ 968,557**	**£ 890,966**	**£ 1,845**	**£ 892,811**	**£ 186·72**	**£ 172·11**	—	**£ 14·61**

NOTE.—Other Tables relating to the above Hospitals are Nos. 8, 25, 31 and 36.

TABLE 18.

INCOME AND EXPENDITURE ON MAINTENANCE ACCOUNT OF GENERAL HOSPITALS WITHOUT MEDICAL SCHOOLS CONTAINING 150 TO 199 AVAILABLE BEDS.

Hospital.	Income.			Expenditure.			Per *occupied* bed.			
	Ordinary.	Extra-ordinary.	Total.	Ordinary.	Extra-ordinary.	Total.	Income.	Expenditure.	Deficit.	Surplus.
LL ..	£ 17,677	£ 400	£ 18,077	£ 14,764	—	£ 14,764	£ 187·23	£ 152·92	—	£ 34·31
MM ..	32,073	628	32,701	24,148	£ 258	24,406	193·19	144·18	—	49·01
NN ..	27,588	1,041	28,629	25,706	2,526	28,232	212·07	209·13	—	2.94
OO ..	20,752	1,044	21,796	24,561	335	24,896	122·21	139·59	£ 17·38	—
PP ..	28,979	2,381	31,360	24,165	402	24,567	223·52	175·10	—	48·42
QQ ..	11,575	1,525	13,100	12,190	—	12,190	118·02	109·82	—	8·20
RR ..	21,117	7,354	28,471	21,933	—	21,933	168·11	129·51	—	38·60
SS ..	24,256	653	24,909	24,827	—	24,827	148·13	147·64	—	·49
TT ..	23,179	211	23,390	20,210	407	20,617	190·94	168·30	—	22·64
UU ..	22,564	746	23,310	21,925	3	21,928	152·92	143·86	—	9·06
VV ..	23,604	1,590	25,194	24,076	1,191	25,267	208·21	208·82	·61	—
WW ..	22,371	1,365	23,736	23,113	—	23,113	145·62	141·80	—	3.82
XX ..	19,977	4,820	24,797	17,670	—	17,670	215·68	153·69	—	61·99
YY ..	22,181	5,219	27,400	23,704	52	23,756	230·25	199·63	—	30·62
Total ..	£ 317,893	£ 28,977	£ 346,870	£ 302.992	£ 5,174	£ 308,166	**£ 176·89**	**£ 157·16**	—	**£ 19·73**

NOTE.—Other Tables relating to the above Hospitals are Nos. 9, 26, 32 and 37.

TABLE 19.

INCOME AND EXPENDITURE ON MAINTENANCE ACCOUNT OF CERTAIN GROUPS OF SPECIAL HOSPITALS.

Hospitals.	Income.			Expenditure.			Per *occupied* bed.		
	Ordinary.	Extra-ordinary.	Total Income available for Maintenance.	Ordinary.	Extra-ordinary.	Total Expenditure on Maintenance.	Income.	Expenditure.	Surplus.
Children's Hospitals	£ 163,016	£ 19,956	£ 182.972	£ 177,524	£ 618	£ 178,142	£ 131·99	£ 128·50	£ 3·49
Ear, Nose and Throat Hospitals	21,701	7,273	28,974	23,517	—	23,517	245·04	198·89	46·15
Eye Hospitals	98,688	30,279	128,967	94,825	97	94,922	245·80	180·91	64·89
Women's Hospitals	64,799	11,600	76,399	63,429	2,946	66,375	209·66	182·15	27·51

NOTE.—Other Tables relating to the above Hospitals are Nos. 10, 33 and 38.

TABLE 20.

ORDINARY INCOME AND EXPENDITURE.

Hospitals.	Year.	No. of Hospitals.	Total Ordinary Income.	Total Ordinary Expenditure.	Deficit.	Surplus.
Group A ..	1922	109	£ 2,684,704	£ 2,799,135	£ 114,431	—
	1923	115	3,008,120	2,866,375	—	£ 141,745
	1924	114	2,823,945	2,912,158	88,213	—
	1925	116	3,014,118	3,018,244	4,126	—
	1926	**118**	**2,957,375**	**3,186,491**	**229,116**	—
Group B ..	1922	164	992,829	942,003	—	50,826
	1923	184	1,085,000	999,279	—	85,721
	1924	197	1,130,204	1,080,533	—	49,671
	1925	198	1,180,145	1,100,171	—	79,974
	1926	**204**	**1,206,877**	**1,226,335**	**19,458**	—
Group C ..	1922	314	497,878	462,358	—	35,520
	1923	325	527,649	485,403	—	42,246
	1924	351	586,518	533,491	—	53,027
	1925	340	606,579	555,062	—	51,517
	1926	**334**	**598,505**	**560,193**	—	**38,312**
Total	1922	587	£ 4,175,411	£ 4,203,496	£ 28,085	—
	1923	624	4,620,769	4,351,057	—	£ 269,712
	1924	662	4,540,667	4,526,182	—	14,485
	1925	654	4,800,842	4,673,477	—	127,365
	1926	**656**	**4,762,757**	**4,973,019**	**210,262**	—

TABLE 21.

HOSPITALS HAVING AN **EXCESS OF ORDINARY INCOME** OVER ORDINARY EXPENDITURE.

Hospitals.	Year.	No. of Hospitals.	Total Ordinary Income.	Total Ordinary Expenditure.	Surplus.
Group A	1922	45 (41%)	£ 1,139,441	£ 998,962	£ 140,479
	1923	73 (63%)	2,005,179	1,723,692	281,487
	1924	52 (46%)	1,251,006	1,104,094	146,912
	1925	59 (51%)	1,511,055	1,333,543	117,512
	1926	**43 (36%)**	**946,826**	**846,113**	**100,713**
Group B	1922	96 (59%)	638,788	544,553	94,235
	1923	118 (64%)	728,719	603,193	125,526
	1924	112 (57%)	682,450	579,110	103,340
	1925	124 (63%)	781,540	658,096	123,444
	1926	**103 (50%)**	**616,242**	**546,505**	**69,737**
Group C	1922	195 (62%)	336,431	282,985	53,446
	1923	224 (69%)	385,712	327,715	57,997
	1924	248 (71%)	455,909	389,961	65,948
	1925	249 (73%)	468,178	402,761	65,417
	1926	**208 (62%)**	**408,115**	**344,871**	**63,244**
Total	1922	336 (57%)	£ 2,114,660	£ 1,826,500	£ 288,160
	1923	415 (67%)	3,119,610	2,654,600	465,010
	1924	412 (62%)	2,389,365	2,073,165	316,200
	1925	432 (66%)	2,760,773	2,394,400	366,373
	1926	**354 (54%)**	**1,971,183**	**1,737,489**	**233,694**

TABLE 22.

HOSPITALS HAVING AN **EXCESS OF ORDINARY EXPENDITURE** OVER ORDINARY INCOME.

Hospitals.	Year.	No. of Hospitals.	Total Ordinary Income.	Total Ordinary Expenditure.	Deficit.
Group A	1922	64 (59%)	£ 1,545,263	£ 1,800,173	£ 254,910
	1923	42 (37%)	1,002,941	1,142,683	139,742
	1924	62 (54%)	1,572,939	1,808,064	235,125
	1925	57 (49%)	1,503,063	1,684,701	181,638
	1926	**75 (64%)**	**2,010,549**	**2,340,378**	**329,829**
Group B	1922	68 (41%)	354,041	397,450	43,409
	1923	66 (36%)	356,281	396,086	39,805
	1924	85 (43%)	447,754	501,423	53,669
	1925	74 (37%)	398,605	442,075	43,470
	1926	**101 (50%)**	**590,635**	**679,830**	**89,195**
Group C	1922	119 (38%)	161,447	179,373	17,926
	1923	101 (31%)	141,937	157,688	15,751
	1924	103 (29%)	130,609	143,530	12,921
	1925	91 (27%)	138,401	152,301	13,900
	1926	**126 (38%)**	**190,390**	**215,322**	**24,932**
Total	1922	251 (43%)	£ 2,060,751	£ 2,376,996	£ 316,245
	1923	209 (33%)	1,501,159	1,696,457	195,298
	1924	250 (38%)	2,151,302	2,453,017	301,715
	1925	222 (34%)	2,040,069	2,279,077	239,008
	1926	**302 (46%)**	**2,791,574**	**3,235,530**	**443,956**

TABLE 23.

ORDINARY INCOME AND EXPENDITURE PER AVAILABLE BED.

Hospitals.	Year.	No. of Hospitals.	No. of available beds.	*Ordinary Income per available bed.	*Ordinary Expenditure per available bed.	*Surplus.	*Deficit.
Group A ..	1922	109	20,960	£ 128	£ 134	—	£ 6
	1923	115	22,071	136	130	£ 6	—
	1924	114	21,624	131	135	—	4
	1925	116	22,281	135	135	—	—
	1926	**118**	**22,832**	**130**	**140**	—	10
Group B ..	1922	164	8,436	118	112	6	—
	1923	184	9,206	118	109	9	—
	1924	197	9,958	113	109	4	—
	1925	198	10,201	116	108	8	—
	1926	**204**	**10,736**	**112**	**114**	—	**2**
Group C ..	1922	314	4,572	109	101	8	—
	1923	325	4,801	110	101	9	—
	1924	351	5,249	112	102	10	—
	1925	340	5,213	116	106	10	—
	1926	**334**	**5,224**	**115**	**107**	**8**	—
Total	1922	587	33,968	£ 123	£ 124	—	£ 1
	1923	624	36,078	128	121	£ 7	—
	1924	662	36,831	123	123	—	—
	1925	654	37,695	127	124	3	—
	1926	**656**	**38,792**	**123**	**128**	—	**5**

* Calculated to the nearest £.

TABLE 24.

ORDINARY INCOME AND EXPENDITURE OF THE 14 HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN ENGLAND AND WALES.

Hospital.	Year.	Ordinary Income.	Ordinary Expenditure.	Ordinary Income per *occupied* bed.	Ordinary Expenditure per *occupied* bed.	Per *occupied* bed.	
						Deficit.	Surplus.
A	1922	£ 33,529	£ 46,686	£ 122·55	£ 170·64	£ 48·09	—
	1923	37,630	45,783	134·12	163·18	29·06	—
	1924	38,143	44,687	137·64	161·26	23·62	—
	1925	38,633	45,701	137·03	162·10	25·07	—
	1926	**41,216**	**48,762**	**151·13**	**178·80**	**27·67**	—
B	1922	24,640	34,902	135·50	191·93	56·43	—
	1923	24,468	33,527	129·10	176·92	47·82	—
	1924	26,041	36,608	130·28	183·15	52·87	—
	1925	26,315	34,941	130·98	173·91	42·93	—
	1926	**27,293**	**37,641**	**136·04**	**187·62**	**51·58**	—
C	1922	60,613	61,132	204·08	205·83	1·75	—
	1923	58,264	66,687	185·55	212·38	26·83	—
	1924	59,374	69,955	186·71	219·98	33·27	—
	1925	60,444	71,313	187·13	220·78	33·65	—
	1926	**67,451**	**75,579**	**206·90**	**231·84**	**24·94**	—
D	1922	29,118	33,822	161·05	187·07	26·02	—
	1923	28,659	34,519	157·73	181·00	23·27	—
	1924	29,119	35,740	156·72	192·36	35·64	—
	1925	30,657	36,063	159·51	187·63	28·12	—
	1926	**32,982**	**37,219**	**170·93**	**192·88**	**21·95**	—
E	1922	43,340	46,038	127·10	135·01	7·91	—
	1923	56,220	50,076	160·17	142·66	—	£ 17·51
	1924	49,078	53,694	143·92	157·46	13·54	—
	1925	51,948	58,285	138·16	155·01	16·85	—
	1926	**52,264**	**63,173**	**128·41**	**155·22**	**26·81**	—
F	1922	32,175	29,886	153·21	142·31	—	10·90
	1923	39,396	37,286	168·36	159·34	—	9·02
	1924	38,316	45,601	139·84	166·43	26·59	—
	1925	46,145	47,629	171·54	177·06	5·52	—
	1926	**41,033**	**47,552**	**149·21**	**172·92**	**23·71**	—
G	1922	40,629	50,010	147·42	181·46	34·04	—
	1923	44,740	53,317	155·51	185·32	29·81	—
	1924	42,716	61,387	142·39	204·62	62·23	—
	1925	45,041	61,619	145·29	198·77	53·48	—
	1926	**44,739**	**66,987**	**140·43**	**209·79**	**69·36**	—
H	1922	32,450	37,538	135·69	156·96	21·27	—
	1923	30,028	37,570	124·14	155·32	31·18	—
	1924	30,525	42,065	124.46	171·52	47·06	—
	1925	33,014	39,762	135·21	162·85	27·64	—
	1926	**29,728**	**43,439**	**123·41**	**180·33**	**56·92**	—
I	1922	77,263	100,541	147·32	191·67	44·35	—
	1923	96,134	98,130	177·70	181·39	3·69	—
	1924	79,906	101,881	148·25	189·02	40·77	—
	1925	83,441	105,924	153·67	195·07	41.40	—
	1926	**86,794**	**108,991**	**160·14**	**201·09**	**40·95**	—
J	1922	62,685	90.723	140·87	203·87	63·00	—
	1923	73,335	91,161	159·08	197·75	38·67	—
	1924	69,753	87,744	149·36	187·89	38·53	—
	1925	130,362	97,443	273·30	204·28	—	69·02
	1926	**79,997**	**98,197**	**169·85**	**208·49**	**38·64**	—
K	1922	89,960	91,555	171·22	174·26	3·04	—
	1923	92,180	87,795	171·53	163·37	—	8·16
	1924	91,785	88,817	170·30	164·78	—	5·52
	1925	90,656	91,720	169·45	171.44	1·99	—
	1926	**82,146**	**93,942**	**147·74**	**168·96**	**21·22**	—

TABLE 24.—*continued.*

Hospital.	Year.	Ordinary Income.	Ordinary Expenditure.	Ordinary Income per *occupied* bed.	Ordinary Expenditure per *occupied* bed.	Per *occupied* bed.	
						Deficit.	Surplus.
L	1922	£ 35,333	£ 39,991	£ 200·76	£ 227·22	£ 26·46	—
	1923	37,943	37,130	224·51	219·70	—	£ 4·81
	1924	40,032	37,661	232·74	218·96	—	13·78
	1925	40,590	38,835	212·51	203·32	—	9·19
	1926	**41,076**	**41,432**	**219·66**	**221·56**	**1·90**	—
M	1922	23,254	24,551	122·39	129·32	6·93	—
	1923	23,464	23,996	131·08	134·06	2·98	—
	1924	22,941	24,169	131·84	138·90	7·06	—
	1925	24,013	24,549	135·67	138·69	3·02	—
	1926	**25,764**	**26,044**	**152·45**	**154·11**	**1·66**	—
*N	1923	67,081	57,414	210·55	180·21	—	30·34
	1924	67,402	62,522	208·16	193·09	—	15·07
	1925	70,071	61,952	205·61	181·78	—	23·83
	1926	**55,644**	**66,067**	**156·92**	**186·31**	**29·39**	—
Totals	1922	£ 584,989	£ 687,375	£ 152·42	£ 179·10	£ 26·68	—
	1923	709,542	754,391	165·55	176·01	10·46	—
	1924	685,131	792,522	157·29	181·94	24·65	—
	1925	771,330	815,736	172·90	182·86	9·96	—
	1926	**708,127**	**855,025**	**156·87**	**189·41**	**32·54**	—

* Recognised as a Medical School during 1923.

NOTE.—Other Tables relating to the above Hospitals are Nos. 7, 16, 30 and 35.

TABLE 25.

ORDINARY INCOME AND EXPENDITURE OF GENERAL HOSPITALS WITHOUT MEDICAL SCHOOLS CONTAINING 200 OR MORE AVAILABLE BEDS.

Hospital.	Year.	Ordinary Income.	Ordinary Expenditure.	Ordinary Income per *occupied* bed.	Ordinary Expenditure per *occupied* bed.	Per *occupied* bed.	
						Deficit.	Surplus.
O	1923	£ 22,583	£ 25,899	£ 128·68	£ 147·57	£ 18·89	—
	1924	24,535	26,317	149·66	160·54	10·88	—
	1925	25,232	26,962	142·74	152·53	9·79	—
	1926	**25,303**	**28,753**	**149·91**	**170·35**	**20·44**	—
P	1923	49,571	34,462	273·12	189·87	—	£ 83·25
	1924	35,574	35,489	187·73	187·28	—	·45
	1925	35,501	33,128	191·86	179·03	—	12·83
	1926	**34,199**	**35,091**	**179·10**	**183·77**	**4·67**	—
Q	1923	32,338	28,776	205·48	182·84	—	22·64
	1924	35,603	36,241	182·73	186·00	3·37	—
	1925	33,767	35,801	180·35	191·21	10·86	—
	1926	**33,571**	**38,115**	**172·16**	**195·46**	**23·30**	—
R	1923	19,829	18,220	124·23	114·15	—	10·08
	1924	19,306	19,093	116·03	114·75	—	1·28
	1925	21,430	22,118	127·54	131·04	3·50	—
	1926	**21,909**	**23,968**	**135·53**	**148·26**	**12·73**	—
S	1923	39,953	27,090	253·67	172·00	—	81·67
	1924	39,033	28,030	196·54	141·14	—	55·40
	1925	40,198	31,532	181·07	142·04	—	39·03
	1926	**40,188**	**37,096**	**156·80**	**144·74**	—	**12·06**
T	1923	44,241	41,997	153·08	145·32	—	7·76
	1924	42,482	44,090	147·00	152·56	5·56	—
	1925	43,102	45,674	146·11	154·83	8·72	—
	1926	**45,832**	**45,458**	**151·26**	**150·03**	—	**1·23**
U	1923	20,579	22,775	99·99	110·56	10·57	—
	1924	21,273	23,348	109·09	119·73	10·64	—
	1925	22,546	23,883	113·30	120·02	6·72	—
	1926	**22,856**	**26,072**	**113·15**	**129·07**	**15·92**	—
V	1923	32,243	34,074	129·70	137·06	7·36	—
	1924	43,774	36,574	179·55	150·02	—	29·53
	1925	41,447	36,842	151·19	134·39	—	16·80
	1926	**41,390**	**37,158**	**152·36**	**136·78**	—	**15·58**
W	1923	38,034	38,471	173·44	175·43	1·99	—
	*1924	Accounts cover a period of nineteen months.					
	1925	38,769	39,806	177·81	182·56	4.75	—
	1926	**47,621**	**42,890**	**205·82**	**185·37**	—	**20·45**
X	1923	60,061	59,487	213·23	211·55	—	1·68
	1924	62,891	67,831	195·92	211·31	15·39	—
	1925	67,840	68,742	209·06	211·84	2.78	—
	1926	**70,705**	**71,344**	**211·38**	**213·29**	**1·91**	—
Y	1923	24,843	27,990	124·84	140·65	15·81	—
	1924	21,692	30,034	107·39	148·68	41·29	—
	1925	23,403	30,452	116·43	151·50	35·07	—
	1926	**22,145**	**30,987**	**109·63**	**153·40**	**43·77**	—
Z	1923	36,156	35,982	182·94	182·06	—	·88
	1924	43,310	36,250	212·82	178·12	—	34·70
	1925	37,743	41,028	177·58	193·04	15·46	—
	1926	**40,410**	**45,060**	**183·91**	**205·07**	**21·16**	—
AA	1923	34,709	32,084	182·68	168·86	—	13·82
	1924	35,531	33,945	192·06	183·49	—	8·57
	1925	34,693	33,724	200·54	194·94	—	5·60
	1926	**33,879**	**34,753**	**183·13**	**187·85**	**4·72**	—
BB	1923	44,463	40,671	177·85	162·68	—	15·17
	1924	41,091	42,847	165·69	172·77	7·08	—
	1925	41,826	41,742	159·64	159·32	—	·32
	1926	**43,488**	**46,301**	**163·18**	**173·74**	**10·56**	—

TABLE 25.—*continued.*

Hospital.	Year.	Ordinary Income.	Ordinary Expenditure.	Ordinary Income per *occupied* bed.	Ordinary Expenditure per *occupied* bed.	Per *occupied* bed.	
						Deficit.	Surplus.
CC	1923	£ 53,144	£ 44,459	£ 201·30	£ 168·40	—	£ 32·90
	1924	51,953	48,175	194·58	180·43	—	14·15
	1925	54,336	46,825	199·25	171·71	—	27·54
	1926	**50,492**	**50,843**	**184·68**	**185·97**	**£ 1·29**	—
DD	1923	30,483	19,009	190·52	118·81	—	71·71
	1924	33,935	20,424	198·45	119·44	—	79·01
	1925	40,397	26,050	210·40	135·68	—	74·72
	1926	**40,719**	**26,655**	**215·44**	**141·03**	—	**74·41**
EE	1923	28,835	28,499	170·12	168·14	—	1·98
	1924	38,094	32,990	215·38	186·52	—	28·86
	1925	39,919	32,157	214·73	172·98	—	41·75
	1926	**41,100**	**33,899**	**226·66**	**186·95**	—	**39·71**
FF	1923	67,415	51,060	240·77	182·36	—	58·41
	1924	46,021	50,906	167·35	185·11	17·76	—
	1925	49,989	49,195	181·78	178·89	—	2·89
	1926	**42,560**	**51,466**	**153·65**	**185·80**	**32·15**	—
GG	1923	38,247	41,130	131·26	141·16	9·90	—
	1924	39,661	40,856	134·71	138·77	4·06	—
	1925	39,124	41,643	136·15	144·92	8·77	—
	1926	**29,014**	**40,543**	**104·39**	**145·86**	**41·47**	—
HH	1923	47,825	44,927	228.28	214·45	—	13·83
	1924	47,578	45,990	216·96	209·72	—	7·24
	1925	45,329	49,763	204·01	223·97	19·96	—
	1926	**39,540**	**53,554**	**151·51**	**205·21**	**53·70**	—
II	1923	28,237	30,559	154·50	167·21	12·71	—
	1924	30,886	33,415	172·11	186·20	14·09	—
	1925	33,915	31,877	188·10	176·79	—	11·31
	1926	**33,742**	**33,097**	**176·95**	**173·56**	—	**3·39**
JJ	1923	26,313	24,120	178·61	163·73	—	14·88
	1924	25,568	25,012	191·66	187·50	—	4·16
	1925	28,261	27,553	204·46	199·34	—	5·12
	1926	**33,812**	**32,530**	**185·54**	**178·50**	—	**7·04**
KK	1923	24,986	20,968	191·46	160·67	—	30·79
	1924	25,049	22,854	169·82	154·94	—	14·88
	1925	26,873	24,138	183·18	164·54	—	18·64
	1926	**25,896**	**25,333**	**155·72**	**152·33**	—	**3·39**
Totals	1923	£ 845,088	£ 772,709	£ 178·02	£ 162·77	—	£ 15·25
	*1924	804,840	780,711	172·55	167·37	—	5.18
	1925	865,640	840,635	173·18	168·17	—	5·01
	1926	**860,371**	**890,966**	**165·86**	**171·76**	**£ 5·90**	—

NOTE.—Other Tables relating to the above Hospitals are Nos. 8, 17, 31 and 36.

TABLE 26.

ORDINARY INCOME AND EXPENDITURE OF GENERAL HOSPITALS WITHOUT MEDICAL SCHOOLS CONTAINING FROM 150 TO 199 AVAILABLE BEDS.

Hospital.	Year.	Ordinary Income.	Ordinary Expenditure.	Ordinary Income per *occupied* bed.	Ordinary Expenditure per *occupied* bed.	Per *occupied* bed.	
						Deficit.	Surplus
LL	1924	£ 13,103	£ 15,197	£ 124·83	£ 144·77	£ 19·94	—
	1925	15,029	14,937	142·46	141·58	—	£ ·88
	1926	**17,677**	**14,764**	**183·09**	**152·92**	—	**30·17**
MM	1924	32,079	22,358	202·01	140·79	—	61·22
	1925	32,734	24,254	197·45	146·30	—	51·15
	1926	**32,073**	**24,148**	**189·48**	**142·66**	—	**46·82**
NN	1924	34,960	22,219	258·96	164·59	—	94·37
	1925	30,363	23,067	230·02	174·75	—	55·27
	1926	**27,588**	**25,706**	**204·36**	**190·41**	—	**13·95**
OO	1924	26,197	21,797	177·04	147·31	—	29·73
	1925	27,166	23,713	152·25	132·90	—	19·35
	1926	**20,752**	**24,561**	**116·36**	**137·71**	**21·35**	—
PP	1924	28,935	22,698	210·77	165·34	—	45·43
	1925	29,589	22,936	211·35	163·80	—	47·55
	1926	**28,979**	**24,165**	**206·55**	**172·23**	—	**34·32**
QQ	1924	12,532	9,957	139·24	110·63	—	28·61
	1925	13,959	10,973	116·33	91·44	—	24·89
	1926	**11,575**	**12,190**	**104·28**	**109·82**	**5·54**	—
RR	1924	19,104	19,686	133·41	137·47	4·06	—
	1925	24,832	21,693	153·27	133·90	—	19·37
	1926	**21,117**	**21,933**	**124·69**	**129·51**	**4·82**	—
SS	1924	18,309	23,400	119·14	152·26	33·12	—
	1925	23,449	23,319	146·62	145·81	—	·81
	1926	**24,256**	**24,827**	**144·24**	**147·64**	**3·40**	—
TT	1924	18,645	18,375	146.58	144·46	—	2.12
	1925	24,562	19,700	187·07	150·04	—	37·03
	1926	**23,179**	**20,210**	**189·22**	**164·98**	—	**24·24**
UU	1924	28,288	21,661	197·42	151·17	—	46·25
	1925	28,446	21,165	189·63	141·09	—	48·54
	1926	**22,564**	**21,925**	**148·03**	**143·84**	—	**4·19**
VV	1924	23,760	23,939	161·63	162·85	1·22	—
	1925	22,772	23,012	160·37	162·06	1·69	—
	1926	**23,604**	**24,076**	**195·07**	**198·98**	**3·91**	—
WW	1924	18,888	20,978	133·96	148·78	14·82	—
	1925	20,517	21,616	130·68	137·68	7·00	—
	1926	**22,371**	**23,113**	**137·25**	**141·80**	**4·55**	—
XX	1924	15,701	16,500	141·59	148·80	7·21	—
	1925	19,763	16,387	173·47	143·83	—	29·64
	1926	**19,977**	**17,670**	**173·76**	**153·69**	—	**20·07**
YY	1924	20,400	22,271	180·53	197·09	16·56	—
	1925	21,053	22,526	179·94	192·53	12·59	—
	1926	**22,181**	**23,704**	**186·39**	**199·19**	**12·80**	—
Total	1924	£ 310,901	£ 281,036	£ 167·76	£ 151·64	—	£ 16·12
	1925	334,234	289,298	169·24	146·49	—	22·75
	1926	**317,893**	**302,992**	**162·12**	**154·52**	—	**7·60**

NOTE.—Other Tables relating to the above Hospitals are Nos. 9, 18, 32 and 37.

ANALYSIS OF SOME OF THE THE VOLUNTARY HOSPITALS

Table 27. The gains and losses under the main headings of Ordinary Income can most easily be seen from the summary on the opposite page.

The net loss of the hospitals as a whole was £4·55. Two points that may be noticed are that Contributory Scheme losses were greatest in the B group, and that both B group and C group are developing payments from patients more than the A group. Lingering doubts regarding the policy of providing beds for paying patients may account for some of the difference. Site restrictions also, in the case of a number of large hospitals, makes development in this direction less easy in Group A than in either of the other two groups.

TABLE 27

ANALYSIS OF THE PRINCIPAL ITEMS OF ORDINARY

Hospitals.	Year.	No. of Hospitals.	No. of available beds.	Investments.				Voluntary	
				Interest from Investments.		Subscriptions.		Donations (including Entertainments, etc.)	
				Total.	Amount per available bed.	Total.	Amount per available bed.	Total.	Amount per available bed.
Group A ..	1922	109	20,960	£ 403,454	£ *19·24*	£ 370,624	£ 17·68	£ 403,335	£ 19·24
	1923	115	22,071	441,887	*20·02*	391,639	17·74	466,526	21·13
	1924	114	21,624	453,866	*20·99*	406,119	18·79	379,448	17·55
	1925	116	22,281	461,979	*20·73*	430,356	19·31	467,329	20·97
	1926	**118**	**22,832**	**476,226**	**20·86**	**425,166**	**18.62**	**434,765**	**19·04**
Group B ..	1922	164	8,436	149,034	*17·66*	131,995	15·64	189,144	22·42
	1923	184	9,206	162,694	*17·67*	137,282	14·90	245,103	26·62
	1924	197	9,958	168,336	*16·90*	141,716	14·23	204,517	20·54
	1925	198	10,201	170,012	*16·67*	143,291	14·05	232,442	22·79
	1926	**204**	**10,736**	**180,249**	**16·79**	**148,879**	**13·87**	**230,252**	**21·45**
Group C ..	1922	314	4,572	75,563	*16·52*	81,847	17·90	126,022	27·56
	1923	325	4,801	79,572	*16·57*	82,209	17·12	124,624	25.93
	1924	351	5,249	89,051	*16·97*	90,368	17·22	135,288	25·77
	1925	340	5,213	90,113	*17·29*	93,263	17·89	133,474	25·60
	1926	**334**	**5,224**	**88, 349**	**16·91**	**91,434**	**17·50**	**128,543**	**24·61**
Total ..	1922	587	33,968	£ 628,051	£ *18·48*	£ 584,466	£ 17·20	£ 718,501	£ 21·15
	1923	624	36,078	684,153	*18·96*	611,130	16·93	836,253	23·17
	1924	662	36,831	711,253	*19·31*	638,203	17·33	719,253	19·53
	1925	654	37,695	722,104	*19·16*	666,910	17·69	833,245	22·10
	1926	**656**	**38,792**	**744,824**	**19·20**	**665,479**	**17·16**	**793,560**	**20·46**

SOURCES OF ORDINARY INCOME OF IN ENGLAND AND WALES.

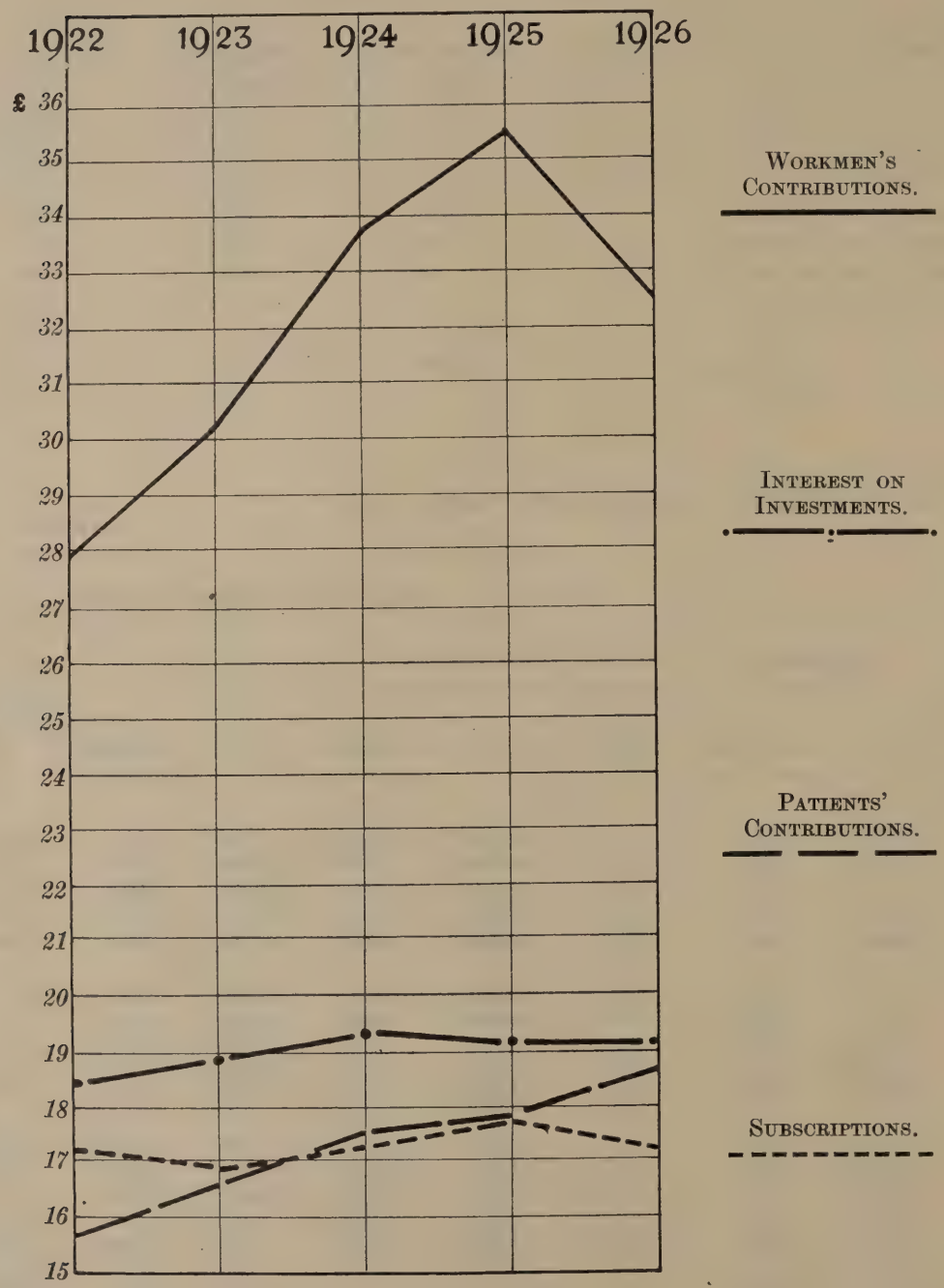
Comparison between 1925 and 1926 of the principal items of Ordinary Income per available bed.
+ = Gains. — = Losses.

	Group A.	Group B.	Group C.
	£	£	£
Interest from Investments	+ ·13	+ ·12	— ·38
Subscriptions	— ·69	— ·18	— ·39
Donations	—1·93	—1·34	— ·99
Workmen's Contributions, etc.	—2·76	—4·72	— ·49
Congregational Collections	— ·06	— ·25	— ·15
Patients' Contributions	— ·20	+3·01	+ ·96
Public Services	— ·17	+ ·06	— ·20
Net Loss	£ 5·68	£ 3·30	£ 1·64

INCOME—HOSPITALS GROUPED ACCORDING TO THEIR SIZE.

Gifts.					Receipts for Services Rendered.					
Workmen's Contributions, Hospital Saturday Funds, and Contributory Schemes		Congregational Collections.		Total of Voluntary Gifts per available bed.	Patients' Contributions.		Public Services.		Total Services rendered per available bed.	Total per available bed from the seven sources.
Total.	Amount per available bed.	Total.	Amount per available bed.		Total.	Amount per available bed.	Total.	Amount per available bed.		
£ 701,673	£ 33·47	£ 102,342	£ 4·88	£ *75·27*	£ 256,175	£ 12·22	£ 397,189	£ 17·99	£ *30·21*	£ 124·72
784,983	35·56	106,741	4·83	*79·26*	291,617	13·21	400,954	18·16	*31·37*	130·65
874,714	40·45	110,364	5·10	*81·89*	296,146	13·70	289,718	13.40	*27·10*	129·98
942,790	42·31	108,662	4·88	*87·47*	304,833	13·68	271,164	12·17	*25·85*	134·05
902,898	**39·55**	**109,941**	**4·82**	**82·03**	**307,806**	**13·48**	**273,951**	**12·00**	**25·48**	**128·37**
191,153	22·65	36,379	4·31	*65·02*	161,505	19·14	83,169	9·85	*28·99*	111·67
235,581	25·58	37,032	4·02	*71·12*	178,514	19·39	80,964	8·79	*28·18*	116·97
287,393	28·86	35,374	3·55	*67·18*	197,655	19·85	78,689	7·90	*27·75*	111·83
304,317	29·83	36,638	3·59	*70·26*	208,314	20·42	70,316	6·89	*27·31*	114·24
269,574	**25·11**	**35,904**	**3·34**	**63·77**	**251,545**	**23·43**	**74,600**	**6·95**	**30·38**	**110·94**
59,547	13·02	19,745	4·31	*62·79*	118,949	26·01	12,505	2·73	*28·74*	108·05
72,058	15·00	19,598	4·08	*62·13*	131,806	27·41	12,345	2·57	*29·98*	108·68
87,046	16·58	20,763	3·96	*63·53*	150,413	28·66	10,273	1·96	*30·62*	111·12
93,893	18·01	20,205	3·88	*65·38*	158,851	30·47	12,313	2·36	*32·83*	115·50
91,548	**17·52**	**19,461**	**3·73**	**63·36**	**164,198**	**31·43**	**11,303**	**2·16**	**33·59**	**113·86**
£ 952,373	£ 28·03	£ 158,466	£ 4.68	£ *71·06*	£ 536,629	£ 15·79	£ 492,863	£ 14·53	£ *30·32*	£ 119·86
1,092,622	30·28	163,371	4·52	*74·90*	601,937	16·67	494,263	13·69	*30·36*	124·22
1,249,153	33·91	166,501	4·52	*75·29*	644,214	17·49	378,680	10·28	*27·77*	122·37
1,341,000	35·58	165,505	4·39	*79·76*	671,998	17·83	353,793	9·39	*27·22*	126 14
1,264,020	**32·58**	**165,306**	**4·26**	**74·46**	**723,549**	**18·65**	**359,854**	**9·28**	**27·93**	**121 59**

ANALYSIS OF ORDINARY INCOME PER AVAILABLE BED OF THE TOTAL NUMBER OF HOSPITALS REVIEWED.



Illustrating Table 27.

Table 28 shows the growth in the invested funds of the Voluntary Hospitals. The trend is better shown by the total figures than by the amount per available bed. Ward additions to an existing hospital and each new hospital itself increases the bed divisor, but brings little into the capital sum to be divided, as such additions to the hospitals as a whole are seldom endowed. In spite of bad times, the hospitals have a capital that is larger by £2,024,147 than it was in the year 1922. There are no means of ascertaining what portion of this may be due to appreciation in market value of investments, but in any case the figure is a remarkable one.

Table 29. So far as the income from public services shows, there does not appear to have been any marked development of public service work in any of the groups. The increase in the amount received from National Health Insurance points to some improvement in the machinery for receiving contributions from the Approved Societies. There is still a considerable sum appearing under the heading " Details not given." As the setting forth of the amounts received from each Public Service source involves no additional labour, we confidently look forward to the time when all Hospital Reports will show their figures under the separate headings. Only one of the 14 Medical School Hospitals receives any payment for work done on behalf of the Education Authorities.

The following analysis of the figures of the Medical School group, under four of the Public Service headings, for the years 1925-1926 shows no marked increase in the amount of work undertaken for the Public Authorities.

ANALYSIS OF SOME OF THE SOURCES OF INCOME FROM PUBLIC SERVICES RECEIVED BY HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS.

Hospital.	Year.	Infant Welfare and Maternity.	Venereal Diseases.	Tuberculosis Cases.	National Health Insurance Act.
A	1925	—	£ 3,741	£ 657	£ 1,414
	1926	—	3,547	502	1,346
B	1925	—	2,236	606	876
	1926	—	3,753	389	996
C	1925	—	4,327	91	2,146
	1926	—	4,396	65	2,332
D	1925	£ 203	—	49	1,656
	1926	40	—	50	1,563
E	1925	—	1,010	—	2,065
	1926	—	1,120	—	1,807
F	1925	—	665	—	1,809
	1926	—	664	—	1,802
G	1925	—	—	—	1,101
	1926	—	—	—	950
H	1925	—	388	—	1,183
	1926	—	250	—	998
I	1925	—	500	2,113	4,246
	1926	—	450	1,735	4,467
J	1925	—	5,561	—	2,837
	1926	—	5,911	—	3,350
K	1925	—	7,941	82	2,637
	1926	—	8,324	208	3,139
L	1925	1,200	1,141	487	—
	1926	1,250	1,121	328	—
M	1925	176	1,020	877	1,165
	1926	226	884	712	1,369
N	1925	1,277	102	—	—
	1926	1,320	194	—	438
Total	1925	£ 2,856	£ 28,632	£ 4,962	£ 23,135
	1926	2,836	30,614	3,989	24,557

The amounts raised under the various main headings of Ordinary Income are matters of rather more importance than might be thought, as they frequently help to locate a source of support which one hospital may not have developed to the full. The following summary is therefore given. It can be used in conjunction with Tables 30, 31, 32 and 33, and from it a hospital can compare its own figures with those of the Group to which it belongs.

SOURCES OF ORDINARY INCOME PER AVAILABLE BED.

Hospitals.	Interest on Investments.	Workmen's Contributions.	Patients' Contributions.	Public Services.
Group A as a whole	£ 20·86	£ 39·55	£ 13·48	£ 12·00
		£ 53·03		
„ B „ „	16·79	25·11	23·43	6·95
		48·54		
„ C „ „	16·91	17·52	31·43	2·16
		48·95		
Medical School Hospitals	22·18	43·86	15·41	13·35
		59·27		
Hospitals without Medical Schools containing 200 or more beds	17·97	53·85	13·19	14·62
		67·04		
ditto, 150 to 199 beds	24·66	53·81	9·63	13·16
		63·44		
Children's Hospitals	21·74	16·36	14·96	6·51
		31·32		
Ear, Nose, and Throat Hospitals ...	7·83	22·53	33·54	6·95
		56·07		
Eye Hospitals	24·02	39·59	13·98	4·54
		53·57		
Women's Hospitals	18·48	41·68	44·94	10·30
		86·62		

TABLE 28.
INVESTED FUNDS.

Hospitals.	Year.	No. of Hospitals.	No. of available beds.	Invested Funds.	
				Total.	Per available bed.
Group A ..	1922	109	20,960	£ 8,645,372	£ 412
	1923	115	22,071	9,121,016	413
	1924	114	21,624	9,321,619	431
	1925	116	22,281	9,715,501	436
	1926	**118**	**22,832**	**9,864,825**	**432**
Group B ..	1922	164	8,436	3,378,364	400
	1923	184	9,206	3,605,286	392
	1924	197	9,958	3,741,395	376
	1925	198	10,201	3,724,514	365
	1926	**204**	**10,736**	**3,849,898**	**359**
Group C ..	1922	314	4,572	1,627,087	356
	1923	325	4,801	1,731,972	361
	1924	351	5,249	1,966,744	375
	1925	340	5,213	1,913,122	367
	1926	**334**	**5,224**	**1,960,247**	**375**
Total ..	1922	587	33,968	£ 13,650,823	£ 402
	1923	**624**	**36,078**	**14,458,274**	**401**
	1924	662	36,831	15,029,758	408
	1925	654	37,695	15,353,137	407
	1926	**656**	**38,792**	**15,674,970**	**404**

TABLE 29.
ANALYSIS OF THE SOURCES OF INCOME FROM PUBLIC SERVICES.

Hospitals.	Year.	War Office or Admiralty.	Ministry of Pensions.	Infant Welfare and Maternity Work.	Venereal Diseases.	Tuber-culosis cases.	Education Authorities.	National Health Insurance Act.	Details not given.
Group A ..	1922	£ 1,713	£ 119,408	£ 6,582	£ 97,001	£ 51,630	£ 11,103	£ 29,825	£ 79,927
	1923	953	64,109	8,828	91,380	55,338	17,676	85,874	76,796
	1924	1,207	31,880	11,086	89,158	28,868	8,519	84,202	34,798
	1925	1,171	19,314	10,389	87,906	25,847	9,935	82,230	34,372
	1926	**1,260**	**14,835**	**10,883**	**87,818**	**23,847**	**8,716**	**88,614**	**37,978**
Group B ..	1922	197	23,340	13,970	13,319	14,599	3,801	1,994	11,949
	1923	86	11,010	20,599	11,641	11,461	3,231	10,384	12,552
	1924	229	11,685	16,915	8,769	5,829	5,099	12,498	17,665
	1925	62	5,982	19,053	5,783	5,467	4,921	12,835	16,213
	1926	**62**	**2,895**	**21,583**	**5,196**	**7,578**	**4,425**	**15,057**	**17,804**
Group C ..	1922	19	1,718	2,741	1,245	2,436	1,439	663	2,244
	1923	10	1,367	2,761	567	2,220	1,524	1,836	2,060
	1924	2	760	2,375	586	25	1,662	2,185	2,678
	1925	6	465	5,273	624	303	1,453	1,972	2,217
	1926	**14**	**267**	**2,949**	**705**	**484**	**1,977**	**3,050**	**1,857**
Total	1922	£ 1,929	£ 144,466	£ 23,293	£ 111,565	£ 68,665	£ 16,343	£ 32,482	£ 94,120
	1923	1,049	76,486	32,188	103,588	69,019	22,431	98,094	91,408
	1924	1,438	44,325	30,376	98,513	34,722	15,280	98,885	55,141
	1925	1,239	25,761	34,715	94,313	31,617	16,309	97,037	52,802
	1926	**1,336**	**17,997**	**35,415**	**93,719**	**31,909**	**15,118**	**106,721**	**57,639**

TABLE 30.

SOME OF THE SOURCES OF ORDINARY INCOME OF THE 14 HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN ENGLAND AND WALES.

Hospital.	Year.	Interest on Investments.	Workmen's Contributions, Hospital Saturday Funds and Contributory Schemes.	Patients' Contributions.	Income from Public Services
A	1922	£ 7,368	£ 4,000	£ 11,034	£ 6,934
	1923	7,794	3,720	11,661	8,236
	1924	7,735	4,280	12,465	7,032
	1925	8,037	4,595	12,675	6,338
	1926	**8,472**	**4,763**	**14,695**	**5,565**
B	1922	4,019	3,262	6,563	4,866
	1923	3,687	3,006	7,035	4,907
	1924	3,854	2,974	8,152	5,116
	1925	3,895	2,986	8,209	3,743
	1926	**3,991**	**2,853**	**8,718**	**5,178**
C	1922	13,528	16,115	3,673	7,061
	1923	12,058	16,450	1,716	8,070
	1924	12,706	17,328	1,802	7,537
	1925	12,664	18,589	2,329	6,712
	1926	**12,751**	**19,942**	**2,801**	**6,925**
D	1922	4,597	7,744	2,744	2,195
	1923	4,572	8,153	2,348	2,721
	1924	4,418	9,057	2,638	2,468
	1925	4,426	9,258	2,429	2,049
	1926	**4,328**	**10,412**	**2,493**	**1,766**
E	1922	4,618	22,666	2,368	2,754
	1923	4,798	31,565	1,870	3,448
	1924	4,888	33,190	1,399	3,119
	1925	4,559	34,301	2,091	3,075
	1926	**5,615**	**32,553**	**2,703**	**2,927**
F	1922	3,210	16,418	2,369	2,234
	1923	3,441	21,441	1,855	2,730
	1924	3,263	25,106	1,615	3,007
	1925	3,367	31,687	2,137	2,474
	1926	**3,539**	**26,180**	**2,208**	**2,466**
G	1922	7,511	5,945	8,529	—
	1923	11,852	4,772	8,654	—
	1924	13,219	4,590	8,739	—
	1925	11,792	4,618	8,141	1,280
	1926	**12,335**	**4,479**	**7,713**	**1,020**
H	1922	5,056	5,374	8,050	1,447
	1923	4,896	5,099	5,940	3,797
	1924	4,585	5,143	5,935	4,048
	1925	4,466	5,474	6,727	4,124
	1926	**4,343**	**5,066**	**5,749**	**3,857**
I	1922	18,016	2,186	10,378	8,757
	1923	18,327	2,491	11,878	8,398
	1924	17,711	4,013	12,719	7,503
	1925	17,950	4,860	13,533	6,967
	1926	**18,204**	**5,250**	**13,784**	**6,931**
J	1922	5,754	27,992	3,511	7,708
	1923	10,891	30,392	3,748	6,856
	1924	9,789	23,227	4,307	6,577
	1925	9,528	29,319	3,750	8,398
	1926	**9,596**	**30,838**	**4,510**	**9,261**
K	1922	8,849	43,648	2,324	9,517
	1923	9,321	44,662	2,030	14,098
	1924	10,034	45,783	1,959	11,190
	1925	10,861	42,936	2,058	10,862
	1926	**13,044**	**33,180**	**1,858**	**11,845**

TABLE 30.—*continued.*

Hospital.	Year.	Interest on Investments.	Workmen's Contributions, Hospital Saturday Funds and Contributory Schemes.	Patients' Contributions.	Income from Public Services
L	1922	£ 2,501	£ 20,479	£ 2,098	£ 2,715
	1923	2,666	21,436	3,660	3,294
	1924	2,637	23,387	4,480	3,057
	1925	2,688	23,516	4,614	3,274
	1926	**2,758**	**24,879**	**4,130**	**3,111**
M	1922	3,467	1,779	986	6,488
	1923	3,773	1,824	952	6,175
	1924	3,635	2,253	1,049	4,900
	1925	3,738	2,497	1,117	4,258
	1926	**3,764**	**2,894**	**1,105**	**4,039**
N*	1923	7,671	24,178	4,940	841
	1924	8,129	25,263	5,080	1,362
	1925	9,851	25,964	5,814	1,529
	1926	**8,661**	**17,006**	**4,939**	**2,188**
Totals	1922	£ 88,494	£ 177,608	£ 64,627	£ 62,676
	1923	105,747	219,189	68,287	73,571
	1924	106,603	225,594	72,339	66,916
	1925	107,822	240,600	75,624	65,083
	1926	**111,401**	**220,295**	**77,406**	**67,079**

*** Recognised as a Medical School during 1923.**

NOTE.—Other Tables relating to the above Hospitals are Nos. 7, 16, 24 and 35.

TABLE 31.

SOME OF THE SOURCES OF ORDINARY INCOME OF THE GENERAL HOSPITALS WITHOUT MEDICAL SCHOOLS IN ENGLAND AND WALES, CONTAINING 200 OR MORE AVAILABLE BEDS.

Hospital.	Year.	Interest on Investments.	Workmen's Contributions, Hospital Saturday Funds and Contributory Schemes.	Patients' Contributions.	Income from Public Services.
O	1923	£ 4,893	£ 4,796	£ 2,579	£ 4,646
	1924	4,794	5,771	2,529	4,266
	1925	5,152	6,590	2,949	3,899
	1926	**5,099**	**6,633**	**3,207**	**4,319**
P	1923	3,474	10,517	1,329	4,750
	1924	4,142	10,636	1,487	3,989
	1925	4,264	11,097	1,606	2,917
	1926	**4,631**	**9,951**	**2,001**	**2,302**
Q	1923	4,781	2,806	7,794	1,321
	1924	5,596	3,671	9,242	1,443
	1925	6,373	4,178	7,459	1,303
	1926	**7,722**	**4,323**	**8,599**	**1,458**
R	1923	3,360	1,856	3,642	5,390
	1924	3,426	2,356	3,460	4,800
	1925	3,468	2,538	5,523	3,314
	1926	**3,618**	**2,699**	**5,607**	**2,895**
S	1923	1,037	28,469	1,359	2,276
	1924	1,152	27,844	1,453	2,399
	1925	1,503	28,189	1,745	3,005
	1926	**1,751**	**27,133**	**1,825**	**3,294**
T	1923	2,667	13,500	1,211	9,465
	1924	2,849	15,000	1,210	7,031
	1925	3,308	15,500	1,108	5,702
	1926	**3,512**	**15,800**	**1,516**	**5,100**
U	1923	2,929	224	4,899	4,817
	1924	2,802	222	5,942	3,973
	1925	2,840	202	6,713	3,814
	1926	**2,756**	**221**	**7,789**	**3,450**
V	1923	6,306	9,730	3,992	514
	1924	10,345	10,678	3,788	2,847
	1925	8,465	12,924	3,717	2,493
	1926	**8,934**	**12,672**	**4,237**	**2,768**
W	1923	4,147	9,348	3,445	9,980
	*1924	Accounts cover a period of nineteen months.			
	1925	4,538	13,352	3,700	5,449
	1926	**5,352**	**23,339**	**2,550**	**5,454**
X	1923	7,386	22,843	298	9,196
	1924	7,514	24,182	667	8,485
	1925	8,440	25,384	923	8,439
	1926	**9,364**	**25,666**	**690**	**9,475**
Y	1923	3,348	3,633	6,217	5,637
	1924	3,104	3,531	6,032	2,653
	1925	3,182	3,580	6,479	2,976
	1926	**3,271**	**3,473**	**6,599**	**1,967**
Z	1923	7,253	3,297	4,226	4,942
	1924	6,931	3,977	4,933	5,129
	1925	7,074	4,545	5,970	3,832
	1926	**7,146**	**4,886**	**6,824**	**3,471**
AA	1923	3,601	10,887	2,314	7,972
	1924	3,676	12,097	2,438	7,242
	1925	4,245	11,841	3,837	4,301
	1926	**3,994**	**12,102**	**3,810**	**2,996**

TABLE 31.—*continued.*

Hospital.	Year.	Interest on Investments.	Workmen's Contributions, Hospital Saturday Funds and Contributory Schemes.	Patients' Contributions.	Income from Public Services.
BB	1923	£ 3,783	£ 18,950	£ 2,289	£ 7,851
	1924	3,878	20,172	2,103	4,306
	1925	3,754	20,698	2,663	4,323
	1926	**3,761**	**21,306**	**2,699**	**4,018**
CC	1923	5,214	23,171	1,733	4,057
	1924	5,396	23,441	1,661	3,010
	1925	5,858	24,203	1,942	2,708
	1926	**5,877**	**22,921**	**1,471**	**2,568**
DD	1923	5,277	11,228	4,287	5,819
	1924	5,302	16,755	3,928	4,352
	1925	5,685	20,674	3,997	3,889
	1926	**5,582**	**20,163**	**3,702**	**5,375**
EE	1923	3,825	5,824	3,246	4,431
	1924	3,821	14,053	6,504	3,742
	1925	3,932	18,852	4,003	3,692
	1926	**3,984**	**19,598**	**3,081**	**3,509**
FF	1923	3,727	25,177	—	2,777
	1924	3,761	27,581	—	4,926
	1925	3,749	31,929	—	4,773
	1926	**3,931**	**25,847**	—	**4,756**
GG	1923	5,137	19,792	2,452	2,040
	1924	4,276	23,460	1,979	2,500
	1925	3,707	23,080	2,702	2,283
	1926	**3,423**	**14,037**	**3,343**	**1,950**
HH	1923	4,662	25,880	—	6,739
	1924	4,338	25,907	—	5,660
	1925	4,035	24,453	—	6,137
	1926	**3,648**	**15,619**	—	**5,290**
II	1923	2,688	9,948	921	5,832
	1924	2,488	13,625	998	4,670
	1925	2,527	13,922	1,404	4,524
	1926	**2,345**	**14,738**	**1,492**	**4,384**
JJ	1923	1,795	5,801	4,113	3,923
	1924	1,912	6,552	3,950	3,524
	1925	1,793	7,632	4,419	3,463
	1926	**1,917**	**9,449**	**4,984**	**4,955**
KK	1923	4,892	8,799	1,513	2,299
	1924	5,230	9,182	1,620	2,144
	1925	5,471	9,069	2,048	1,760
	1926	**5,670**	**8,892**	**2,709**	**1,552**
Totals	1923	£ 96,182	£ 276,476	£ 63,859	£ 116,674
	*1924	96,733	300,693	65,924	93,091
	1925	103,363	334,432	74,907	89,096
	1926	**107,288**	**321,468**	**78,735**	**87,306**

TABLE 32

SOME OF THE SOURCES OF ORDINARY INCOME OF THE GENERAL HOSPITALS WITHOUT MEDICAL SCHOOLS IN ENGLAND AND WALES, CONTAINING FROM 150 TO 199 AVAILABLE BEDS.

Hospital.	Year.	Interest on Investments.	Workmen's Contributions, Hospital Saturday Funds and Contributory Schemes.	Patients' Contributions.	Income from Public Services
LL	1924	£ 1,068	£ 3,862	£ 1,816	£ 1,717
	1925	1,081	4,495	2,778	1,684
	1926	**1,081**	**5,537**	**2,616**	**1,805**
MM	1924	7,920	13,786	389	3,844
	1925	8,360	14,085	371	3,779
	1926	**8,665**	**13,632**	**410**	**3,711**
NN	1924	4,457	12,643	781	2,019
	1925	4,624	14,002	1,199	2,110
	1926	**4,737**	**12,936**	**1,257**	**1,978**
OO	1924	1,644	13,687	59	2,906
	1925	1,300	13,913	141	3,182
	1926	**1,306**	**10,089**	**202**	**2,818**
PP	1924	7,902	8,483	1,178	1,411
	1925	8,275	9,142	1,374	1,157
	1926	**8,537**	**9,240**	**1,679**	**1,371**
QQ	1924	2,337	7,457	109	32
	1925	2,784	8,133	163	213
	1926	**2,715**	**6,247**	**85**	**137**
RR	1924	3,137	5,084	1,982	1,363
	1925	3,072	4,546	2,086	1,511
	1926	**3,148**	**7,595**	**2,148**	**1,521**
SS	1924	1,344	4,876	2,483	3,751
	1925	1,332	6,089	2,330	3,397
	1926	**1,435**	**9,636**	**2,258**	**3,693**
TT	1924	4,409	4,358	1,835	2,916
	1925	4,523	5,558	2,382	2,900
	1936	**4,750**	**3,851**	**4,953**	**3,261**
UU	1924	3,133	17,336	1,307	2,837
	1925	3,617	16,545	1,202	3,094
	1926	**3,681**	**10,350**	**1,022**	**3,177**
VV	1924	2,267	7,925	3,294	2,699
	1925	2,269	8,212	3,281	2,360
	1926	**2,079**	**9,554**	**2,886**	**1,817**
WW	1924	3,142	7,575	1,722	610
	1925	3,050	7,395	2,472	821
	1926	**2,976**	**7,524**	**1,647**	**2,220**
XX	1924	3,086	2,111	29	1,346
	1925	3,141	2,980	473	1,156
	1926	**3,462**	**9,402**	**499**	**1,472**
YY	1924	7,499	4,934	286	1,396
	1925	7,359	5,412	394	1,201
	1926	**7,545**	**6,868**	**249**	**973**
Totals	1924	£ 53,345	£ 114,117	£ 17,270	£ 28,847
	1925	54,787	120,507	20,646	28,565
	1926	**56,117**	**122,461**	**21,911**	**29,954**

NOTE.— Other Tables relating to the above Hospitals are Nos. 9, 18, 26 and 37.

TABLE 33.

SOME OF THE SOURCES OF ORDINARY INCOME OF CERTAIN GROUPS OF SPECIAL HOSPITALS.

Hospitals.	No. of Hpls.	No. of available beds.	Interest on Investments.	Workmen's Contributions, Hospital Saturday Funds and Contributory Schemes.	Patients' Contributions.	Income from Public Services.
Children's Hospitals	18	1668	£ 36,270	£ 27,290	£ 24,956	£ 10,852
Ear, Nose and Throat Hospitals ..	7	173	1,355	3,898	5,802	1,203
Eye Hospitals ..	19	783	18,811	30,998	10,944	3,555
Women's Hospitals	8	412	7,612	17,172	18,514	4,243

NOTE.—Other Tables relating to the above Hospitals are Nos. 10, 19 and 38.

SECTION 4.

ANALYSIS OF THE PRINCIPAL ITEMS OF ORDINARY EXPENDITURE OF THE VOLUNTARY HOSPITALS IN ENGLAND AND WALES.

Tables 34 to 38 may be summarised thus :—

	Provisions.	Surgery and Dispensary.	Domestic.	Salaries and Wages.	Total under the four Headings.
Average of all the Hospitals ...	£ 27·12	£ 16·29	£ 24·97	£ 41·69	£ 110·07
Group A	27·80	18·17	26·19	45·97	118·13
„ B	26·34	14·19	23·37	34·88	98·78
„ C	25·44	11·54	22·43	35·34	94·75
Medical School Hospitals ...	35·17	24·86	34·19	65·57	159·79
200 or more beds	34·30	23·11	31·18	57·44	146·03
150 to 199 beds	30·26	20·63	29·49	51·59	131·97
Children's Hospitals	25·44	12·57	26·39	43·60	108·00
Ear, Nose and Throat Hospitals	30·56	27·70	37·23	65·89	161·38
Eye Hospitals	33·69	21·75	34·14	59·79	149·37
Women's Hospitals	35·31	24·72	35·49	56·63	152·15

The group figures show a natural gradation. From them the Committee of a new hospital would be able to estimate with some accuracy the amount of money which it would be necessary to raise to meet the main items of expenditure in maintaining their institution. This applies more especially to the General Hospitals. The figures that relate to the special groups are introduced for the first time this year and must be taken as arithmetically correct so far as the information given in the Annual Reports go. The groups are, however, rather small and there are, no doubt, unrevealed circumstances that, if taken into account, would modify the figures. For example, it is probably due to the large amount of out-patient work that the cost of Surgery and Dispensary is high in the Ear, Nose and Throat, and Eye Hospitals. A comparison between the figures in the summary and those given in the Statistical Report of King Edward's Hospital Fund for London shows that in the Eye Hospitals in London, Surgery and Dispensary does not cost per bed one quarter of the figure £ 21·75. The figures in the King's Fund tables show in-patient and out-patient cost separately, a practice we should follow were the data available for the purpose. The same reason accounts to some extent for the high figure of £161·38 given in the total column against the Ear, Nose and Throat Hospitals. No doubt in time it will be possible to separate In-patient from Out-patient costs. In the meantime, it is satisfactory to note that those Reports in which a separation is made confirm in the majority of cases an estimate given in our Seventh Annual Report. The figure of a third of a pound is easy to remember, and a Committee that wishes to arrive at some idea of the cost of its Out-patient department where a full range of treatment is provided, will not be far out in basing their calculation on 6s. 8d. per Out-patient treated.

At the same time, while these tables may, and no doubt do, supply information of a kind that can be made use of for Administrative purposes, it is impossible to regard them as wholly satisfactory, and this is the more to be regretted in as much as the steps necessary to improve them are neither difficult nor costly. For reasons that are well known to every hospital Administrator, the differences which the tables show between the highest and the lowest costs in, say, the columns under the headings " Provisions " and " Surgery and Dispensary " are in no way an indication of the relative quality of the food or drugs provided, or of the efficiency of the Administrative machine in the matters of purchase, issue or control. Consequently, it is impossible for the figures to exercise the stimulating

effect that comparison has. After all, comparison is only a form of mental competition, and as the hospitals are, by their nature, freed from that competitive struggle that is the characteristic of commercial life, it would be in no way a bad thing that they should be supplied with the material against which to compare their own standards of costs and efficiency.

Were it possible to convey to one hospital Administrator the information that at another institution the patients and staff were as well fed as at his own and at a cost per bed per year of £28 against his £42, he would, without delay, take most searching steps to find out how this could be done, and, having found out, he would set about doing it forthwith. He knows, however, that possibly a dozen differences between the fields covered by the two figures account for the higher or the lower cost, and as he has no means of ascertaining or of valuing those differences, he may well be excused for relying entirely upon his own experience and for resting satisfied with the reflection that if his costs are higher than those of another institution, or have increased during the year under consideration, there are ample reasons for it. And yet it may be that this mental defence, perfectly understandable in the circumstances, does not cover all the ground. Purchase, issue, preparation, service, can and do affect cost, and there is no one who can say that he has nothing to learn in any one of these respects. In two hospitals of equal administrative efficiency, the introduction in one of some improved method would almost certainly be reflected in cost, and cost would serve as a signal pointing towards enquiry. As it is, cost, presented upon a bed basis, does little of the kind, and a very great deal of valuable information concerning improvements in administrative machinery, instead of being year by year automatically brought to light and made available for every hospital, remains to a large extent buried.

There are none of the headings " Provisions," " Surgery and Dispensary," " Domestic," " Salaries and Wages," which do not suffer from these disadvantages, but they all could be easily improved. For example, every hospital has a roll of staff, just as it keeps a register of patients, and is able without difficulty to give the number which are fed daily, wholly or partially, under the categories :—

Patients.
Doctors.
Nurses.
Lay Staff—
    Male.
    Female.

The cost of provisions could then be related to the number fed instead of to the bed, and tables prepared upon this basis. Such tables, though by no means perfect, would be a distinct advance on those prepared on a bed basis and would involve no extra book-keeping of any kind whatever—nothing more than a table in the Annual Report giving the staff numbers and stating which received food.

" Surgery and Dispensary " would also be greatly improved by a separation of out-patient from in-patient costs, or even by an estimation of this cost made and given in the Report.

Again, Laundry costs taken out on the excellent basis which is provided in the Revised Uniform System of Hospital Accounts supplies admirable material for analysis, and provides administrative data which increases in value with every addition to the field covered. Several hospitals already give most interesting details regarding this department. These details, however, lose a good deal of their value, firstly because the number of hospitals supplying them is too few, and secondly because they do not all publish the information in the same form.

The matter of hospital statistics is sometimes treated as if the choice lay between the present bed basis and a full and complete series of departmental costs. That the ideal towards which all may work is a system of accounts which is based upon the use to which a thing is put, not the name by which it is called, all will agree, but ideals can only be approached by gradual steps. The three suggestions made with regard to " Provisions," " Surgery and Dispensary " and the Laundry are of the nature of such steps.

Although it is well known to those who give a moment's consideration to the matter, that facts lie dormant until related to something by which they can be measured, such as time, quantity, or cost,

yet it is matter for wonder that the Reports of so many institutions, by no means all hospitals, contain isolated figures that for this very reason possess little or no value, even in the localities in which they are produced. It is this profusion of sterile numbers that is, no doubt, partly accountable for much of the distaste that many have for statistics of any kind. This is to be regretted, for frequently the facts to which these figures might be related, and which would bring them to life, are either already available or could be ascertained with the minimum of trouble.

TABLE 34.

ANALYSIS OF THE PRINCIPAL ITEMS OF

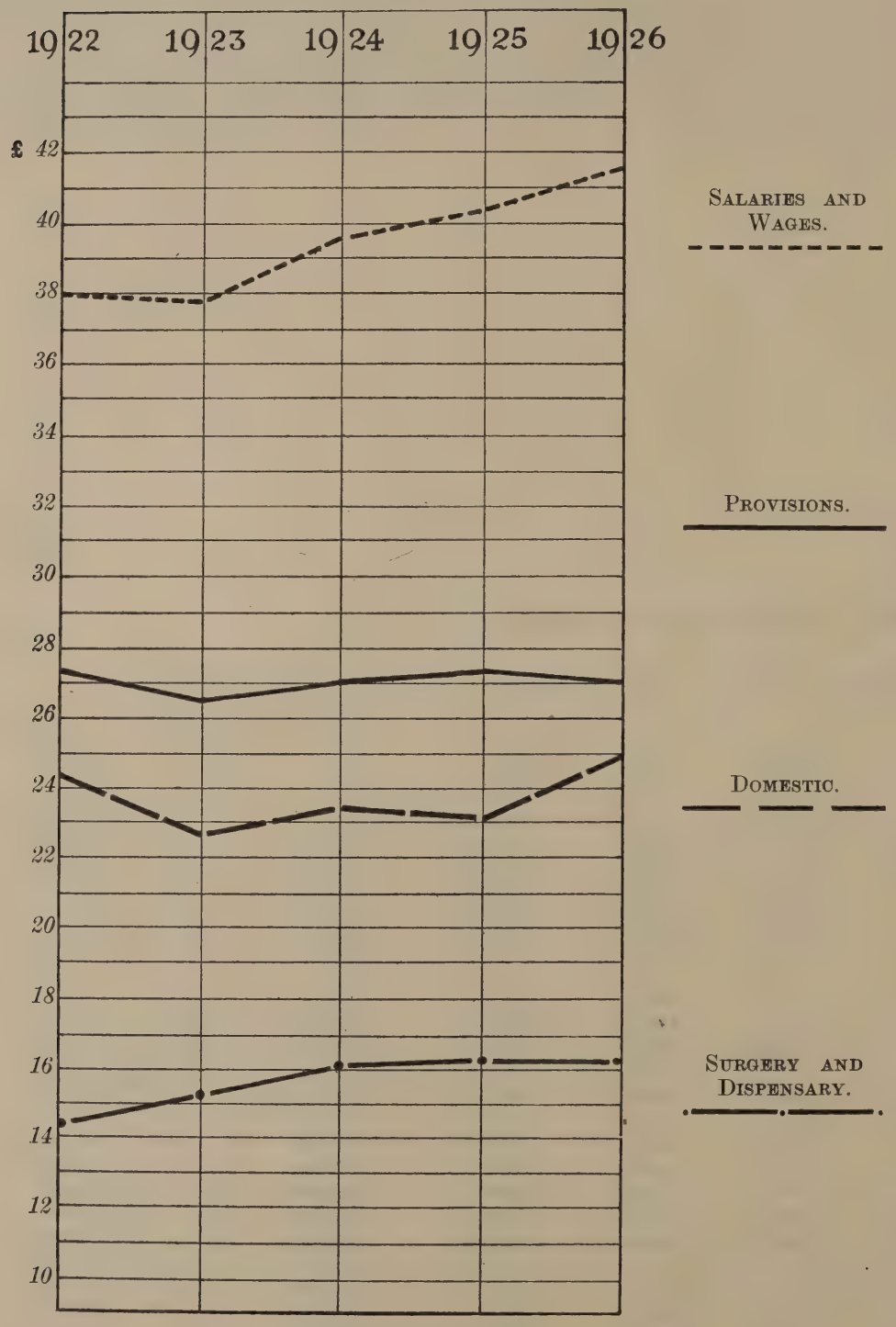
Hospitals.	Year.	No. of Hospitals giving details.	No. of available beds.	Provisions.		Surgery and Dispensary.	
				Total.	Per *available* bed.	Total.	Per *available* bed.
Group A ..	1922	109	20,960	£ 587,357	£ 28·02	£ 331,407	£ 15·81
	1923	115	22,071	603,529	27·34	371,651	16·84
	1924	114	21,624	605,628	28·01	395,394	18·28
	1925	116	22,281	628,815	28.21	410,361	18·42
	1926	**118**	**22,832**	**634,727**	**27·80**	**415,016**	**18·17**
Group B ..	1922	163	8,403	225,202	26.80	114,744	13.65
	1923	176	8,835	225,633	25·54	120,566	13·65
	1924	183	9,260	242,271	26·16	130,700	14·12
	1925	184	9,491	247,403	26·07	131,263	13·83
	1926	**189**	**9,980**	**262,854**	**26·34**	**141,598**	**14·19**
Group C ..	1922	283	4,223	107,826	25·53	41,406	9·81
	1923	282	4,271	108,122	25·32	45,978	10·77
	1924	297	4,530	113,394	25·03	48,124	10·62
	1925	295	4,581	119,155	26·01	52,971	11·56
	1926	**294**	**4,662**	**118,609**	**25·44**	**53,781**	**11·54**
Total	1922	555	33,586	£ 920,385	£ 27·40	£ 487,557	£ 14·52
	1923	573	35,177	937,284	26·64	538,195	15·30
	1924	594	35,414	961,293	27·14	574,218	16·21
	1925	595	36,353	995,373	27·38	594,595	16·36
	1926	**601**	**37,474**	**1,016,190**	**27·12**	**610,395**	**16·29**

Table 39 gives the fuel and light bill for the year of 90% of the Voluntary Hospitals in England and Wales. It is just over half a million pounds or £ 13·51 per available bed per annum. This, though in itself a large sum, assumes its proper proportions when regarded as an expenditure of less than 1/- per day to provide, not only for the lighting, heating, and supply of hot water to each ward bed, but also the provision of similar services to the staff in attendance on each patient both in and out, and the numerous adjuncts of a scientific character which often make heavy calls upon boilers and meters of all kinds.

ORDINARY EXPENDITURE BY GROUP AVERAGES.

Domestic.		Salaries and Wages.		Total Expenditure under the four headings.	
Total.	Per *available* bed.	Total.	Per *available* bed.	Total.	Per *available* bed.
£ 532,131	£ 25·39	£ 877,450	£ 41·87	£ 2,328,345	£ 111·09
519,668	23.54	914,095	41·42	2,408,943	109·14
533,242	24·66	952,126	44·03	2,486,390	114·98
536,557	24·08	1,002,159	44·98	2,577,892	115·69
598,056	**26·19**	**1,049,564**	**45·97**	**2,697,363**	**118·13**
198,191	23·59	273,653	32·57	811,790	96·61
190,405	21·55	289,179	32·73	825,783	93·47
205,571	22·20	307,147	33·17	885,689	95·65
206,810	21·79	319,689	33·68	905,165	95·37
233,216	**23·37**	**348,134**	**34·88**	**985,802**	**98·78**
92,281	21·85	123,949	29·35	365,462	86·54
95,435	22·34	129,430	30·30	378,965	88·73
97,967	21·63	144,818	31·97	404,303	89·25
100,986	22·04	152,820	33·36	425,932	92·97
104,547	**22·43**	**164,766**	**35·34**	**441,703**	**94·75**
£ 822,603	£ 24·49	£ 1,275,052	£ 37·96	£ 3,505,597	£ 104·37
805,508	22·90	1,332,704	37·89	3,613,691	102·73
836,780	23·63	1,404,091	39·65	3,776,382	106·63
844,353	23·23	1,474,668	40·56	3,908,989	107·53
935,819	**24·97**	**1,562,464**	**41·69**	**4,124,868**	**110·07**

ANALYSIS OF ORDINARY EXPENDITURE PER AVAILABLE BED OF THE TOTAL NUMBER OF HOSPITALS REVIEWED.



Illustrating Table 34.

TABLE 35.

ANALYSIS OF THE PRINCIPAL ITEMS OF ORDINARY EXPENDITURE OF THE 14 HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN ENGLAND AND WALES.

Hospital.	Year.	Average No. of beds occupied daily.	Provisions.		Surgery and Dispensary.		Domestic.		Salaries and Wages.	
			Total.	Per *occupied* bed.	Total.	Per *occupied* bed.	Total.	Per *occupied* bed.	Total.	Per *occupied* bed.
A ..	1922	273·59	£ 7,853	£ 28·7	£ 7,266	£ 26·6	£ 8,086	£ 29·5	£ 15,082	£ 55·1
	1923	280·56	7,822	27·9	8,272	29·5	7,396	26·4	14,339	51·1
	1924	277·12	8,469	30·6	7,715	27·8	6,799	24·5	13,929	50·3
	1925	281·93	8,578	30·4	8,170	29·0	7,051	25·0	14,037	50·0
	1926	**272·72**	**8,104**	**29·72**	**8,332**	**30·55**	**8,322**	**30·51**	**14,351**	**52·62**
B ..	1922	181·85	6,885	37·8	4,163	22·9	7,533	41·4	10,381	57·1
	1923	189·50	7,100	37·5	4,695	24.8	6,462	34·1	10,827	57·1
	1924	199·88	7,515	37·6	5,577	27·9	6,275	31·4	11,681	58·4
	1925	200·91	7,541	37·5	5,470	27·2	6,053	30·1	11,414	56·8
	1926	**200·62**	**7,453**	**37·15**	**5,631**	**28·07**	**6,746**	**33·63**	**12,099**	**60·31**
C ..	1922	297·00	11,056	37·2	5,626	18·9	11,945	40·2	19,263	64·9
	1923	314·00	11,697	37·3	8,884	28·3	12,710	40·5	19,480	62·0
	1924	318·00	12,896	40·6	9,293	29·2	12,834	40·4	20,789	65·4
	1925	323·00	12,646	39·1	9,912	30·7	13,539	41·9	21,745	67·3
	1926	**326·00**	**12,362**	**37·92**	**10,148**	**31·13**	**16,386**	**50·26**	**22,953**	**70·41**
D ..	1922	180·80	6,106	33·8	4,924	27·2	5,693	31·5	12,197	67·5
	1923	181·70	6,306	34·7	5,216	28·7	5,742	31·6	12,332	67·9
	1924	185·80	6,443	34.7	5,995	32·3	5,534	29·8	12,673	68·2
	1925	192·20	6,518	33·9	5,586	29·1	5,936	30·9	13,503	70·3
	1926	**192·96**	**6,586**	**34·13**	**4,412**	**22·86**	**6,718**	**34·82**	**14,292**	**74·07**
E ..	1922	341·00	11,544	33·8	8,572	25·1	8,312	24·4	12,165	35·7
	1923	351·00	13,157	37·5	9,936	28·3	8,955	25·5	12,733	36·3
	1924	341·00	14,622	42·9	10,054	29·5	9,310	27·3	13,888	49·7
	1925	376·00	14,998	39·9	11,085	29·5	11,008	29·3	15,016	39·9
	1926	**407·00**	**15,716**	**38·61**	**10,433**	**25·63**	**12,487**	**30·68**	**15,760**	**38·72**
F ..	1922	210·00	6,560	31·2	4,953	23·6	6,012	28·6	8,801	41·9
	1923	234·00	7,839	33·5	7,111	30·4	7,953	34·0	9,714	41·5
	1924	274·00	9,791	35·7	8,045	29·4	9,806	35·8	12,000	43·8
	1925	269·00	9,668	35·9	8,531	31·7	9,513	35·4	13,281	49·4
	1926	**275·00**	**8,539**	**31·05**	**7,084**	**25·76**	**9,461**	**34·40**	**13,160**	**47·85**
G ..	1922	275·60	8,510	30·9	5,728	20·8	10,498	38·1	17,287	62·7
	1923	287·70	9,383	32·6	6,247	21·7	10,974	38·1	18,020	62·6
	1924	300·00	12,079	40·3	8,099	27·0	12,489	41·6	19,062	63·5
	1925	310·00	12,709	41·0	8,501	27·4	11,394	36·8	19,501	62·9
	1926	**319·30**	**13,482**	**42·22**	**7,897**	**24·73**	**13,427**	**42·05**	**20,095**	**62·93**
H ..	1922	239·15	6,597	27·6	5,268	22·0	5,457	22·8	15,223	63·7
	1923	241·88	6,654	27·5	5,167	21·4	5,706	23·6	14,643	60·5
	1924	245·25	7,709	31·4	6,940	28·3	5,609	22·9	15,210	62·0
	1925	244·17	7,862	32·2	5,705	23·4	5,573	22·8	15,388	63·0
	1926	**240·88**	**8,108**	**33·66**	**5,488**	**22·78**	**6,328**	**26·27**	**16,629**	**69·03**
I ..	1922	524·46	19,612	37·4	7,379	14·0	20,077	38·3	38,121	72·7
	1923	541·00	20,415	37·7	7,049	13·0	15,782	29·2	39,571	73·1
	1924	539·00	20,965	38·9	7,556	14·4	17,235	32·0	40,536	75·2
	1925	543·00	22,286	41·0	7,520	13·8	15,455	28·5	41,614	76·6
	1926	**542·00**	**21,775**	**40·18**	**8,511**	**15·70**	**19,462**	**35·91**	**41,842**	**77·20**
J ..	1922	445·00	14,000	31·5	15,035	33·8	18,258	41·0	28,841	64·8
	1923	461·00	13,672	29·7	16,252	35·3	15,995	34·7	30,008	65·1
	1924	467·00	13,619	29·2	14,960	32·0	15,198	32·5	29,945	64·1
	1925	477·00	14,119	29·6	16,765	35·1	18,621	39·0	32,808	68·8
	1926	**471·00**	**13,873**	**29·45**	**16,564**	**35·17**	**15,671**	**33·27**	**35,767**	**75·94**
K ..	1922	525·40	15,567	29·6	11,278	21·5	14,063	26·8	44,631	84·9
	1923	537·40	14,356	26·7	10,629	19·8	13,501	25·1	43,748	81·4
	1924	539·00	14,730	27·3	10,661	19·8	13,123	24·3	43,971	81·6
	1925	535·00	15,100	28·2	10,779	20·1	13,335	24·9	44,308	82·8
	1926	**556·00**	**15,355**	**27·62**	**11,034**	**19·85**	**14,796**	**26·61**	**45,699**	**82·19**

TABLE 35.—*continued.*

Hospital.	Year.	Average No. of beds occupied daily.	Provisions.		Surgery and Dispensary.		Domestic.		Salaries and Wages.	
			Total.	Per *occupied* bed.	Total.	Per *occupied* bed.	Total.	Per *occupied* bed.	Total.	Per *occupied* bed.
L ..	1922	176·00	£ 7,334	£ 41·7	£ 4,546	£ 25·8	£ 7,067	£ 40·2	£ 14,257	£ 81·0
	1923	169·00	6,923	40·9	4,177	24·7	5,853	34·6	13,710	81·1
	1924	172·00	7,104	41·3	5,054	29·4	5,920	34·4	14,652	85·2
	1925	191·00	7,220	37·8	4,763	24·9	6,144	32·2	15,113	79·1
	1926	**187·00**	**7,183**	**38·41**	**5,013**	**26·81**	**6,928**	37·05	**15,074**	**80·61**
M ..	1922	168·00	6,355	37·8	3,627	21·6	4,414	26·3	7,027	41·8
	1923	179·00	5,924	33·1	3,301	18·4	4,296	24·0	6,601	36·9
	1924	174·00	5,682	32·1	3,886	22·3	4,346	25·0	6,775	38·9
	1925	177·00	6,256	35·3	3,576	20·2	4,392	24·8	7,285	41·2
	1926	**169·00**	**6,470**	**38·28**	**3,574**	**21·15**	**4,747**	28·09	**7,359**	**43·55**
N* ..	1923	318·60	11,653	36·6	7,442	23·4	11,258	35·3	19,666	61·7
	1924	323·80	13,058	40·3	8,579	26·5	12,825	39·6	19,902	61·5
	1925	340·80	13,087	38·4	9,170	26·9	10,571	31·0	20,491	60·1
	1926	**354·60**	**13,734**	**38·73**	**8,119**	**22·90**	**12,877**	36·31	**20,912**	**58·97**
Total ..	1922	3,837·85	£ 127,979	£ 33·3	£ 88,365	£ 23·0	£ 127,415	£ 33·5	£ 243,276	£ 63·4
	1923	4,286·34	142,901	33·3	104,378	24·4	132,583	30·9	265,392	61·9
	1924	4,355·85	154,682	35·5	112,414	25·8	137,303	31·5	275,013	63·1
	1925	4,461·01	158,588	35·5	115,533	25·9	138,585	31·1	285,554	64·0
	1926	**4,514·08**	**158,740**	**35·17**	**112,240**	**24·86**	**154,356**	34·19	**295,992**	**65·57**

* Recognised as a Medical School during 1923.

Note:—Other Tables relating to the above Hospitals are Nos. 7, 16, 24 and 30.

TABLE 36.

ANALYSIS OF THE PRINCIPAL ITEMS OF ORDINARY EXPENDITURE OF THE GENERAL HOSPITALS WITHOUT MEDICAL SCHOOLS IN ENGLAND AND WALES, CONTAINING 200 OR MORE AVAILABLE BEDS.

Hospital.	Year.	Average No. of beds occupied daily.	Provisions.		Surgery and Dispensary.		Domestic.		Salaries and Wages.	
			Total.	Per *occupied* bed.	Total.	Per *occupied* bed.	Total.	Per *occupied* bed.	Total.	Per *occupied* bed.
O	1923	175·50	£ 5,926	£ 33·77	£ 3,603	£ 20·53	£ 4,251	£ 24·22	£ 9,802	£ 55.85
	1924	163·93	5,900	35·99	3,739	22·81	4,246	25·90	9,862	60·77
	1925	176·77	6,097	34.49	3,805	21·53	4,224	23·90	10,059	56·90
	1926	**168·79**	**6,312**	**37·40**	**3,674**	**21·77**	**4,643**	**27·51**	**10,226**	**60·58**
P	1923	181·50	7,049	38·84	3,666	20·20	5,715	31.49	12,603	69·44
	1924	189·50	7,096	37·45	3,718	19·62	5,961	31·46	13,567	71·59
	1925	185·04	6,033	32·60	3,876	20·95	5,904	31·91	12,973	70·11
	1926	**190·95**	**5,924**	**31·02**	**4,223**	**22·12**	**6,566**	**34·39**	**13,309**	**69·70**
Q	1923	157·38	6,219	39·52	3,501	22·25	5,316	33·78	9,017	57·29
	1924	194·84	7,273	37·33	4,277	21·95	6,929	35·05	11,294	57·97
	1925	187·23	7,186	38·38	4,546	24·28	5,725	30·58	11,806	63·06
	1926	**195·00**	**7,731**	**39·65**	**4,616**	**23·67**	**7,207**	**36·96**	**12,458**	**63·89**
R	1923	159·62	4,478	28·05	2,999	18·79	2,590	16·23	5,709	35·77
	1924	166·39	4,513	27·12	2,706	16·26	2,878	17·30	6,535	39·28
	1925	168·02	4,895	29·13	3,199	19·04	3,318	19·75	7,847	46·64
	1926	**161·66**	**4,948**	**30·61**	**3,248**	**20·09**	**3,867**	**23·92**	**8,613**	**53·28**
S	1923	157·50	5,871	37·28	4,720	29·97	5,113	32·46	8,121	51·56
	1924	198·60	6,266	31·56	4,712	23·72	5,362	27·00	8,197	41·27
	1925	222·00	7,355	33·13	5,356	24·13	5,691	25·64	9,412	42·40
	1926	**256·30**	**8,240**	**32·15**	**5,943**	**23·19**	**7,005**	**27·33**	**10,938**	**42·68**
T	1923	289·00	7,978	27·61	5,860	20·28	7,790	26·95	14,473	50·08
	1924	289·00	8,488	29·37	6,326	21·89	8,520	29·48	14,912	51·60
	1925	295·00	8,911	30·21	6,547	22·19	8,743	29·64	15,262	51·74
	1926	**303·00**	**9,327**	**30·78**	**6,536**	**21·57**	**8,259**	**27·26**	**15,529**	**51·25**
U	1923	206·00	5,575	27·04	3,008	14·60	3,075	14·93	6,545	31·77
	1924	195·00	5,377	27·57	3,431	17·59	3,365	17·26	7,971	40·88
	1925	199·00	5,511	27·69	3,609	18·14	3,316	16·66	8,181	41·11
	1926	**202·00**	**5,623**	**27·84**	**4,282**	**21·20**	**3,826**	**18·94**	**8,738**	**43·26**
V	1923	248·60	8,752	35·21	5,287	21·27	4,906	19·73	9,340	37·57
	1924	243·80	9,019	36·99	6,604	27·09	4,784	19·62	9,875	40·50
	1925	274·14	9,570	34·91	5,832	21·27	5,081	18·53	9,744	35·54
	1926	**271·66**	**8,734**	**32·15**	**6,343**	**23·35**	**5,492**	**20·22**	**10,351**	**38·10**
W	1923	219·29	8,372	38·18	5,811	26·50	6,697	30·54	11,979	54·63
	1924*	Accounts cover a period of nineteen months.								
	1925	218·04	9,406	43·14	5,468	25·08	8,469	38·84	11,996	55·02
	1926	**231·37**	**8,962**	**38·73**	**5,976**	**25·83**	**9,988**	**43·17**	**11,950**	**51·65**
X	1923	281·20	11,580	41·18	6,864	24·41	9,178	32·64	23,073	82·05
	1924	321·00	14,199	44·23	6,333	19·73	11,627	36·22	25,805	80·39
	1925	324·50	14,980	46·16	6,739	20·77	11,063	34·09	26,047	80·27
	1926	**334·50**	**15,376**	**45·97**	**6,197**	**18·53**	**9,813**	**29·34**	**27,751**	**82·96**
Y	1923	199·00	6,306	31·69	4,033	20·27	5,006	25·16	9,652	48·50
	1924	202·00	6,529	32·32	4,912	24·32	5,401	26·74	9,754	48·29
	1925	201·00	6,772	33·69	4,935	23·56	4,880	24·28	10,435	51·92
	1926	**202·00**	**6,806**	**33·69**	**4,911**	**24·31**	**4,956**	**24·53**	**10,508**	**52·02**
Z	1923	197·64	6,402	32·39	7,141	36·13	5,246	26·54	12,002	60·73
	1924	203·51	7,019	34·49	6,277	30·84	5,711	28·06	12,324	60·56
	1925	212·54	8,573	40·34	7,368	34·67	6,130	28·84	12,888	60·64
	1926	**219·73**	**10,154**	**46·21**	**7,248**	**32·99**	**7,072**	**32·18**	**14,685**	**66·83**
AA	1923	190·00	6,143	32·33	5,997	31·56	6,441	33·90	8,563	45·07
	1924	185·00	6,302	34·06	6,538	35·34	6,705	36·24	9,003	48·66
	1925	173·00	6,472	37·40	5,455	31·53	6,161	35·61	9,950	57·51
	1926	**185·00**	**6,964**	**37·64**	**5,869**	**31·72**	**5,767**	**31·17**	**10,399**	**56·21**

TABLE 36.—*continued.*

Hospital.	Year.	Average No. of beds occupied. daily.	Provisions.		Surgery and Dispensary.		Domestic.		Salaries and Wages.	
			Total.	Per *occupied* bed.	Total.	Per *occupied* bed.	Total.	Per *occupied* bed.	Total.	Per *occupied* bed.
BB	1923	250·00	£ 9,104	£ 36·42	£ 4,560	£ 18·24	£ 8,770	£ 35·08	£ 12,901	£ 51·60
	1924	248·00	8,632	34·81	5,775	23·29	8,948	36·08	14,115	56·92
	1925	262·00	7,942	30·31	5,722	21·84	7,808	29·80	14,566	55·60
	1926	**266·50**	**7,968**	**29·90**	**5,719**	**21·46**	**10,830**	**40·64**	**14,738**	**55·30**
CC	1923	264·00	7,618	28·86	6,801	25·76	6,908	26·17	17,885	67·75
	1924	267·00	8,138	30·48	7,174	26·87	8,119	30·41	18,302	68·55
	1925	272·70	7,653	28·06	7,286	26·71	6,851	25·12	18,847	69·11
	1926	**273·40**	**8,424**	**30.81**	**6,817**	**24·93**	**8,920**	**32·63**	**20,814**	**76·13**
DD	1923	160·00	3,573	22·33	2,311	14·44	3,419	21·37	6,073	37·96
	1924	171·00	4,389	25·67	2,416	14.13	3,459	20·23	6,568	38·41
	1925	192·00	4,974	25·91	2,745	14·30	4,023	20·95	10,657	55·51
	1926	**189·00**	**5,016**	**26·54**	**2,513**	**13·30**	**4,430**	**23·44**	**11,686**	**61·83**
EE	1923	169·50	4,980	29·38	3,853	22·73	4,342	25·62	11,110	65·55
	1924	176·87	5,453	30·83	4,356	24·63	5,181	29·29	13,442	76·00
	1925	185·90	5,347	28·76	4,711	25·34	5,109	27·48	12,529	67·40
	1926	**181·33**	**5,295**	**20·20**	**5,175**	**28·54**	**5,489**	**30·27**	**12,470**	**68·77**
FF	1923	280·00	9,540	34·07	6,480	23·14	9,968	35·60	15,814	56·48
	1924	275·00	8,829	32·10	7,584	27·58	11,630	42·29	16,407	59·66
	1925	275·00	8,777	31·92	7,171	26·08	9,332	33·93	17,142	62·33
	1926	**277·00**	**8,756**	**31·61**	**8,325**	**30·05**	**9,180**	**33·14**	**17,135**	**61·86**
GG	1923	291·38	10,137	34·79	4,868	16·71	7,641	26·22	13,843	47·51
	1924	294·42	10,144	34·45	4,780	16·24	8,019	27·24	13,937	47·34
	1925	287·35	10,407	36·22	4,867	16·94	8,863	30·84	13,385	46·58
	1926	**277·95**	**9,980**	**35·91**	**4,274**	**15·38**	**8,712**	**31·34**	**13,619**	**49·00**
HH	1923	209·50	9,472	45·21	4,191	20·00	7,435	35·49	12,155	58·02
	1924	219·29	10,181	46·43	5,457	24·88	8,058	36·75	12,390	56·50
	1925	222·19	9,995	44·98	5,518	24·83	8,184	36·83	13,247	59·62
	1926	**260·97**	**9,636**	**36·92**	**5,813**	**22·27**	**10,355**	**39·68**	**14,266**	**54·67**
II	**1923**	**182·76**	**5,483**	**30·00**	**6,253**	**34·21**	**6,400**	**35·02**	**8,159**	**44·10**
	1924	179·46	5,452	30·38	5,822	32·44	5,769	32·15	9,884	55·08
	1925	180·30	5,328	29·55	5,454	30·25	5,003	27·76	9,981	55·36
	1926	**190·69**	**5,596**	**29·35**	**5,283**	**27·70**	**6,017**	**31·55**	**10,387**	**54·47**
JJ	1923	147·32	4,954	33·63	2,297	15·59	5,553	37·69	6,377	43·29
	1924	133·40	5,551	41·61	2,590	19·42	5,536	41·50	6,662	49·94
	1925	138·22	6,181	44·72	2,990	21·63	6,508	47·08	6,993	50·59
	1926	**182·24**	**6,894**	**37·83**	**3,718**	**20·40**	**8,621**	**47·32**	**8,284**	**45·46**
KK	1923	130·50	4,373	33·51	2,079	15·93	4,297	32·93	7,611	58·32
	1924	147·50	4,828	32·73	2,322	15·74	5,614	38·06	8,184	55·48
	1925	146·70	5,127	34·95	2,750	18·75	4,964	33·84	9,072	61·84
	1926	**166·30**	**5,245**	**31·54**	**3,200**	**19·24**	**4,711**	**28·33**	**9,086**	**54·64**
Totals ..	1923	4747·19	£ 159,885	£ 33·68	£ 106,183	£ 22·37	£ 136,057	£ 28·66	£ 252,807	£ 53·25
	1924*	4664·51	159,578	34·21	107,849	23·12	141,822	30·40	258,990	55·52
	1925	4998·64	173,492	34·71	115,949	23·20	145,350	29·08	283,019	56·62
	1926	**5187·34**	**177,911**	**34·30**	**119,903**	**23·11**	**161,726**	**31·18**	**297,940**	**57·44**

NOTE.—Other Tables relating to the above Hospitals are Nos. 8, 17, 25 and 31.

TABLE 37.

ANALYSIS OF THE PRINCIPAL ITEMS OF ORDINARY EXPENDITURE OF THE GENERAL HOSPITALS WITHOUT MEDICAL SCHOOLS IN ENGLAND AND WALES, CONTAINING FROM 150 TO 199 AVAILABLE BEDS.

Hospital.	Year.	Average No. of beds occupied daily.	Provisions.		Surgery and Dispensary.		Domestic.		Salaries and Wages.	
			Total.	Per *occupied* bed.	Total.	Per *occupied* bed.	Total.	Per *occupied* bed.	Total.	Per *occupied* bed.
LL	1924	104·97	£ 2,892	£ 27·55	£ 2,252	£ 21·45	£ 3,122	£ 29·74	£ 4,286	£ 40·83
	1925	105·50	2,912	27·60	2,532	24·00	2,912	27·60	4,576	43·37
	1926	**96·55**	**2,906**	**30·10**	**1,891**	**19·59**	**3,390**	**35·11**	**4,614**	**47·79**
MM	1924	158·80	5,848	36·83	2,361	14·87	3,288	20·71	6,690	42·13
	1925	165·78	5,881	35·47	2,924	17·64	3,644	21·96	6,862	41·39
	1926	**169·27**	**5,524**	**32·63**	**2,806**	**16·58**	**4,264**	**25·19**	**7,048**	**41·64**
NN	1924	135·00	4,716	34·93	4,104	30·40	3,407	25·23	7,829	57·93
	1925	132·00	4,988	37·79	4,005	30·34	3,797	28·77	9,031	68·42
	1926	**135·00**	**4,866**	**36·04**	**4,327**	**32·05**	**4,450**	**32·96**	**8,552**	**63·35**
OO	1924	147·97	3,959	26·76	3,700	25·01	3,548	23·98	6,993	47·26
	1925	178·43	4,294	24·07	3,922	21·98	3,449	19·33	8,193	45·92
	1926	**178·35**	**4,184**	**23·45**	**3,675**	**20·61**	**4,019**	**22·53**	**8,940**	**50·13**
PP	1924	137·28	5,422	39·50	3,062	22·30	4,670	34·02	7,092	51·66
	1925	140·00	5,477	39·12	3,444	24·60	4,158	29·70	7,145	51·04
	1926	**140·30**	**5,229**	**37·27**	**3,653**	**26·04**	**4,273**	**30·46**	**8,001**	**57·03**
QQ	1924	90·00	2,313	25·70	913	10·14	2,849	31·66	3,601	40·11
	1925	120·00	2,568	21·40	1,042	8·68	3,338	27·82	3,777	31·48
	1926	**111·00**	**2,815**	**25·36**	**1,225**	**11·04**	**3,676**	**33·12**	**4,213**	**37·95**
RR	1924	143·20	4,371	30·52	2,090	14·59	4,077	28·47	5,519	38·54
	1925	162·01	4,739	29·25	2,779	17·15	4,363	26·93	6,183	38·16
	1926	**169·36**	**5,010**	**29·58**	**2,511**	**14·83**	**4,260**	**25·15**	**6,478**	**38·25**
SS	1924	153·68	4,251	27·66	4,332	28·19	3,999	26·02	8,155	53·06
	1925	159·93	4,723	29·53	4,151	25·96	3,909	24·44	8,216	51·37
	1926	**168·16**	**4,667**	**27·75**	**4,079**	**24·26**	**4,877**	**29·00**	**8,570**	**50·96**
TT	1924	127·20	4,061	31·93	1,913	15·04	4,140	32·55	6,028	47·39
	1925	131·30	3,953	30·11	2,246	17·11	4,766	36·30	6,574	50·07
	1926	**122·50**	**3,444**	**28·11**	**2,149**	**17·54**	**4,694**	**38·32**	**6,699**	**54·61**
UU	1924	143·29	4,270	29·80	3,097	21·61	3,444	24·04	8,206	57·27
	1925	150·01	3,914	26·09	2,902	19·35	3,400	22·67	8,201	54·67
	1926	**152·43**	**3,718**	**24·39**	**2,561**	**16·80**	**3,612**	**23·70**	**8,510**	**55·83**
VV	1924	147·00	5,009	34·07	3,452	23·48	4,091	27·83	6,866	46·71
	1925	142·00	4,997	35·19	3,156	22·23	4,017	28·29	7,162	50·44
	1926	**121·00**	**4,918**	**40·64**	**2,953**	**24·40**	**4,494**	**37·14**	**7,433**	**61·43**
WW.. ..	1924	141·00	4,863	34·49	2,527	17·92	4,173	29·60	7,275	51·60
	1925	157·00	4,516	28·76	2,681	17·08	3,790	24·14	7,224	46·01
	1926	**163·00**	**4,584**	**28·12**	**2,914**	**17·88**	**4,344**	**26·65**	**7,523**	**46·15**
XX	1924	110·89	3,372	30·41	2,098	18·92	3,205	28·90	5,369	48·42
	1925	113·93	3,251	28·54	1,715	15·05	2,859	25·09	5,624	49·36
	1926	**114·97**	**3,106**	**27·02**	**2,857**	**24·85**	**3,370**	**29·31**	**5,757**	**50·07**
YY	1924	113·00	4,266	37·75	3,066	27·13	2,974	26·32	8,557	75·72
	1925	117·00	4,216	36·03	3,139	26·83	3,302	28·22	8,980	76·75
	1926	**119·00**	**4,373**	**36·75**	**2,844**	**23·90**	**4,100**	**34·45**	**8,825**	**74·16**
Totals ..	1924	1853·28	£ 59,613	£ 32·17	£ 38,967	£ 21·03	£ 50,987	£ 27·51	£ 92,466	£ 49·89
	1925	1974·89	60,429	30·60	40,638	20·58	51,704	26·18	97,748	49·50
	1926	**1960·89**	**59,342**	**30·26**	**40,445**	**20·63**	**57,823**	**29·49**	**101,163**	**51·59**

NOTE.—Other Tables relating to the above Hospitals are Nos. 9, 18, 26 and 32.

TABLE 38.

ANALYSIS OF THE PRINCIPAL ITEMS OF ORDINARY EXPENDITURE OF CERTAIN GROUPS OF SPECIAL HOSPITALS.

Hospitals.	No. of Hpls.	Average No. of beds occupied daily.	Provisions.		Surgery and Dispensary.		Domestic.		Salaries and Wages.	
			Total.	Per *occupied* bed.	Total.	Per *occupied* bed.	Total.	Per *occupied* bed.	Total.	Per *occupied* bed.
Children's Hpls.	18	1386·29	£ 35,262	£ 25·44	£ 17,420	£ 12·57	£ 36,582	£ 26·39	£ 60,440	£ 43·60
Ear, Nose, and Throat Hpls.	7	118·24	3,614	30·56	3,275	27·70	4,402	37·23	7,791	65·89
Eye Hpls. ..	19	524·68	17,679	33·69	11,413	21·75	17,915	34·14	31,370	59·79
Women's Hpls.	8	364·39	12,868	35·31	9,008	24·72	12,934	35·49	20,637	56·63

NOTE.—Other Tables relating to the above Hospitals are Nos. 10, 19 and 33

TABLE 39.

EXPENDITURE ON FUEL AND LIGHT.

Hospitals	Year.	No. of Hospitals giving details.	No. of available beds.	Expenditure on Coal, Coke, Gas and Electricity.	Expenditure per available bed.
Group A	1922	109	20,960	£ 301,793	£ 14·40
	1923	115	22,071	281,154	12·74
	1924	114	21,624	289,403	13·38
	1925	116	22,281	282,899	12·70
	1926	**118**	**22,832**	**337,250**	**14·77**
Group B	1922	153	7,939	96,410	12·14
	1923	170	8,582	92,085	10.73
	1924	186	9,399	101,943	10·85
	1925	180	9,176	99,244	10·82
	1926	**191**	**10,072**	**120,088**	**11.92**
Group C	1922	235	3,517	37,422	10·64
	1923	266	3,994	39,979	9·96
	1924	288	4,432	45,614	10·29
	1925	277	4,354	45,759	10·51
	1926	**284**	**4,480**	**47,724**	**10·65**
Total	1922	497=85% (*a*)	32,416=95·43% (*b*)	£ 435,625	£ 13·44
	1923	551=88% (*a*)	34,647=96·03% (*b*)	413,036	11·92
	1924	588=89% (*a*)	35,455=96·26% (*b*)	436,960	12·32
	1925	573=88% (*a*)	35,811=95·00% (*b*)	427,902	11·95
	1926	**593=90%** (*a*)	**37,384=96·37%** (*b*)	**505,062**	**13·51**

(*a*) Percentage of Hospitals reviewed.

(*b*) Percentage of total available beds in Hospitals reviewed.

SECTION 5.

TOTAL RECEIPTS AND TOTAL EXPENDITURE OF THE VOLUNTARY HOSPITALS IN ENGLAND AND WALES.

The financial position of the English and Welsh Provincial hospitals for the year 1926 may be summarised as follows :—

Ordinary Income	£ 4,762,757	Ordinary Expenditure	£ 4,973,019
Extraordinary Income ...	517,138	Extraordinary Expenditure ...	21,007
Receipts for Capital Purposes	1,294,824	Capital Expenditure	1,418,309
		Surplus for the year	162,384
	£ 6,574,719		£ 6,574,719

Table 44 divides the earmarked legacy from the free. Probably the amount of free legacies is an under-statement. A hospital may place a free legacy direct to a special fund and unless there is in the text of the Report some definite allusion to this, there is no option except to treat it in these tables as earmarked. The relationship of the earmarked legacy to the free may be taken as approxi mately £1 is to £4. The main point about the legacy as a source of support to hospitals generally and over a period of several years, is its stability. It can be counted on to produce about £15 per bed per year. The possibility of strengthening this sturdy prop has been alluded to in Section 2.

TABLE 40.

TOTAL RECEIPTS AND TOTAL EXPENDITURE.

Hospitals.	Year.	No. of Hospitals.	Total Receipts.	Total Expenditure.	Surplus.	Deficit.
Group A ..	1922	109	£ 3,491,545	£ 3,127,931	£ 363,614	—
	1923	115	4,211,350	3,575,704	635,646	—
	1924	114	3,713,091	3,556,831	156,260	—
	1925	116	4,132,923	3,728,454	404,469	—
	1926	**118**	**3,898,853**	**3,902,759**	—	**£ 3,906**
Group B ..	1922	164	1,250,681	1,061,348	189,333	—
	1923	184	1,437,548	1,246,068	191,480	—
	1924	197	1,658,400	1,475,183	183,217	—
	1925	198	1,671,981	1,477,662	194,319	—
	1926	**204**	**1,823,146**	**1,789,962**	**33,184**	—
Group C ..						
	1922	314	753,712	646,723	106,989	—
	1923	325	735,887	631,950	103,937	—
	1924	351	824,358	710,692	113,666	—
	1925	340	823,695	712,499	111,196	—
	1926	**334**	**852,720**	**719,614**	**133,106**	—
Total ..	1922	587	£ 5,495,938	£ 4,836,002	£ 659,936	—
	1923	624	6,384,785	5,453,722	931,063	—
	1924	662	6,195,849	5,742,706	453,143	—
	1925	654	6,628,599	5,918,615	709,984	—
	1926	**656**	**6,574,719**	**6,412,335**	**162,384**	—

TABLE 41.

HOSPITALS HAVING AN **EXCESS OF TOTAL RECEIPTS** OVER TOTAL EXPENDITURE.

Hospitals.	Year.	No. of Hospitals.	Total Receipts.	Total Expenditure.	Surplus.
Group A	1922	77 (71%)	£ 2,609,243	£ 2,101,929	£ 507,314
	1923	81 (70%)	3,347,221	2,494,243	852,978
	1924	66 (58%)	2,192,212	1,713,102	479,110
	1925	74 (64%)	2,872,640	2,222,945	649,695
	1926	**61 (52%)**	**2,106,904**	**1,741,359**	**365,545**
Group B	1922	124 (76%)	1,024,741	786,663	238,078
	1923	126 (68%)	1,062,048	762,146	299,902
	1924	130 (66%)	1,212,639	919,582	293,057
	1925	130 (66%)	1,170,975	877,941	293,034
	1926	**118 (58%)**	**1,043,366**	**796,220**	**247,146**
Group C	1922	222 (71%)	601,104	440,734	160,370
	1923	239 (74%)	570,762	414,779	155,983
	1924	253 (72%)	615,483	444,146	171,337
	1925	226 (66%)	608,498	461,992	146,506
	1926	**217 (65%)**	**596,913**	**415,101**	**181,812**
Total	1922	423 (72%)	£ 4,235,088	£ 3,329,326	£ 905,762
	1923	446 (71%)	4,980,031	3,671,168	1,308,863
	1924	449 (68%)	4,020,334	3,076,830	943,504
	1925	430 (66%)	4,652,113	3,562,878	1,089,235
	1926	**396 (60%)**	**3,747,183**	**2,952,680**	**794,503**

TABLE 42.

HOSPITALS HAVING AN **EXCESS OF TOTAL EXPENDITURE** OVER TOTAL RECEIPTS.

Hospitals.	Year.	No. of Hospitals.	Total Receipts.	Total Expenditure.	Deficit.
Group A	1922	32 (29%)	£ 882,302	£ 1,026,002	£ 143,700
	1923	34 (30%)	864,129	1,081,461	217,332
	1924	48 (42%)	1,520,879	1,843,729	322,850
	1925	42 (36%)	1,260,283	1,505,509	245,226
	1926	**57 (48%)**	**1,791,949**	**2,161,400**	**369,451**
Group B	1922	40 (24%)	225,940	274,685	48,745
	1923	58 (32%)	375,500	483,922	108,422
	1924	67 (34%)	445,761	555,601	109,840
	1925	68 (34%)	501,006	599,721	98,715
	1926	**86 (42%)**	**779,780**	**993,742**	**213,962**
Group C	1922	92 (29%)	152,608	205,989	53,381
	1923	86 (26%)	165,125	217,171	52,046
	1924	98 (28%)	208,875	266,546	57,671
	1925	114 (34%)	215,197	250,507	35,310
	1926	**117 (35%)**	**255,807**	**304,513**	**48,706**
Total	1922	164 (28%)	£ 1,260,850	£ 1,506,676	£ 245,826
	1923	178 (29%)	1,404,754	1,782,554	377,800
	1924	213 (32%)	2,175,515	2,665,876	490,361
	1925	224 (34%)	1,976,486	2,355,737	379,251
	1926	**260 (40%)**	**2,827,536**	**3,459,655**	**632,119**

TABLE 43.

TOTAL RECEIPTS AND TOTAL EXPENDITURE OF GENERAL AND SPECIAL HOSPITALS SHOWN SEPARATELY.

Hospitals.	No. of Hospitals.	Available Beds.	Total Receipts.	Total Expenditure.	Surplus.	Deficit
General Hospitals—						
Group A	107	20,870	£ 3,620,821	£ 3,635,848	—	£ 15,027
Group B	146	7,511	1,218,155	1,208,395	£ 9,760	—
Group C	301	4,624	743,471	632,324	111,147	—
Total ..	**554**	**33,005**	**£ 5,582,447**	**£ 5,476,567**	**£ 105,880**	—
Special Hospitals—						
Group A	11	1,962	£ 278,032	£ 266,911	£ 11,121	—
Group B	58	3,225	604,991	581,567	23,424	—
Group C	33	600	109,249	87,290	21,959	—
Total ..	**102**	**5,787**	**£ 992,272**	**£ 935,768**	**£ 56,504**	—

TABLE 44.

LEGACIES RECEIVED.

Hospitals.	Year.	No. of Hospitals.	No. of available beds.	Free † Legacies.	Earmarked	Total Legacies.	Per available bed.*		
							Free.	Earmarked	Total.
Group A ..	1924	114	21,624	£ 279,733	£ 92,159	£ 371,932	£ 13	£ 4	£ 17
	1925	116	22,281	333,158	75,233	408,239	15	3	18
	1926	**118**	**22,832**	**304,158**	**92,528**	**396,686**	**13**	**4**	**17**
Group B ..	1924	197	9,958	128,921	22,200	151,121	13	2	15
	1925	198	10,201	115,640	20,156	135,796	11	2	13
	1926	**204**	**10,736**	**144,001**	**8,800**	**152,801**	**13**	**1**	**14**
Group C ..	1924	351	5,249	45,384	7,900	53,284	9	2	11
	1925	340	5,213	34,062	4,248	38,310	6	1	7
	1926	**334**	**5,224**	**62,984**	**31,070**	**94,054**	**12**	**6**	**18**
Total ..	1924	662	36,831	£ 454,078	£ 122,259	£ 576,337	£ 12	£ 3	£ 15
	1925	654	37,695	482,860	99,637	582,497	13	2	15
	1926	**656**	**38,792**	**511,143**	**132,398**	**643,541**	**13**	**3**	**16**

* Calculated to the nearest £.

† Free Legacies are included under " Extraordinary Income " in Tables 11 to 19 inclusive.

SECTION 6.

VOLUME OF WORK DONE IN THE VOLUNTARY HOSPITALS IN SCOTLAND.

The volume of work in the Scottish hospitals appears to have grown during 1926 approximately at the rate of 6% in the case of In-patients and 9% in the case of Out-patients. The corresponding figures for the English and Welsh hospitals are 8% and 6% respectively.

In the Medical School group more patients were treated in 1926 than in 1925. This result was achieved by shortening the stay of the patients, and not by crowding the wards still further. In 1925 the percentage of available beds occupied was almost 99%. It is satisfactory to note that this percentage has been somewhat reduced.

TABLE 45.

NUMBER OF IN-PATIENTS AND OUT-PATIENTS TREATED AND PERCENTAGE OF AVAILABLE BEDS OCCUPIED.

Hospitals.	Year.	No. of Hospitals giving details.	No. of available beds.	Percentage of available beds occupied daily.	No. of New In-patients.	No. of New Out-patients.
Group A	1922	18	5,316	87·28%	78,143	250,327
	1923	19	5,435	90·81%	82,822	257,700
	1924	19	5,495	91·80%	88,140	290,730
	1925	19	5,532	94·21%	92,000	298,238
	1926	**19**	**5,694**	**92·20%**	**95,239**	**318,351**
Group B	1922	19	1,122	83·57%	14,074	35,711
	1923	20	1,149	86·53%	14,728	36,894
	1924	20	1,210	82·47%	15,067	38,363
	1925	26	1,389	80·67%	18,577	47,047
	1926	**26**	**1,428**	**83·40%**	**20,398**	**61,164**
Group C	1922	35	537	61·16%	6,692	25,534
	1923	46	728	63·32%	7,544	30,590
	1924	53	844	59·33%	8,063	30,622
	1925	48	777	58·26%	6,887	30,629
	1926	**53**	**901**	**59·41%**	**8,079**	**26,315**
Total	1922	72=91% (*a*)	6,975=99% (*b*)		98,909	311,572
	1923	85=99% (*a*)	7,312=99% (*b*)		105,094	325,184
	1924	92=99% (*a*)	7,549=99% (*b*)		111,270	359,715
	1925	93=98% (*a*)	7,698=99% (*b*)		117,464	375,914
	1926	**98=99%** (*a*)	**8,023=99%** (*b*)		**123,716**	**405,830**

(*a*) Percentage of Hospitals reviewed.
(*b*) Percentage of total available beds in Hospitals reviewed.

TABLE 46.

NUMBER OF PATIENTS TREATED IN GENERAL AND SPECIAL HOSPITALS DURING 1926 SHOWN SEPARATELY.

Hospitals.	No. of Hospitals giving details.	No. of available beds.	No. of New In-patients.	No. of New Out patients.
General Hospitals—				
Group A—				
Medical School Hospitals	6	3,330	57,623	202,803
		* 352	5,407	
Hospitals without Medical Schools ..	9	1,286	16,422	39,604
		* 11	202	
Group B	15	738	10,393	25,029
		* 56	564	
Group C	45	753	6,951	6,575
Totals of General Hospitals	**75**	**6,107**	**91,389**	**274,011**
		* **419**	**6,173**	
Special Hospitals—				
Group A	4	658	14,987	75,944
		* 57	598	
Group B	11	634	9,441	36,135
Group C	8	148	1,128	19,740
Totals of Special Hospitals	**23**	**1,440**	**25,556**	**131,819**
		* **57**	**598**	

* Figures relating to Auxiliary Hospitals and Convalescent Homes under control of the Hospitals.

TABLE 47.

NUMBER OF SURGICAL OPERATIONS UNDER GENERAL ANÆSTHETIC.

Hospitals.	Year.	No. of Hospitals giving details.	No. of available beds.	No. of operations.
Group A	1922	18	5,316	53,523
	1923	19	5,435	59,064
	1924	18	5,391	61,082
	1925	18	5,428	64,749
	1926	**19**	**5,694**	**68,636**
Group B	1922	13	779	9,094
	1923	16	889	9,717
	1924	17	1,043	10,489
	1925	23	1,275	14,348
	1926	**24**	**1,348**	**19,757**
Group C	1922	28	399	5,910
	1923	38	591	7,549
	1924	44	693	8,610
	1925	**40**	629	8,550
	1926	**49**	**829**	**8,835**
Total	1922	59=75% (*a*)	6,494=91·79% (*b*)	68,527
	1923	73=85% (*a*)	6,915=94·39% (*b*)	76,330
	1924	79=85% (*a*)	7,127=93·99% (*b*)	80,181
	1925	81=85% (*a*)	7,332=94·83% (*b*)	87,647
	1926	**92=93%** (*a*)	**7,871=97·92%** (*b*)	**97,228**

(*a*) Percentage of Hospitals reviewed.

(*b*) Percentage of total available beds in Hospital reviewed.

TABLE 48.

SURVEY OF THE WORK DONE IN THE SIX HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN SCOTLAND.

1	2	3	4	5	6	7	8	9
Hospital.	Year.	No. of available beds.	Average No. of beds occupied daily.	Percentage of available beds occupied.	No. of New In-patients.	Average length of stay per In-patient (days).	No. of New Out-patients.	No. of Surgical Operations.
A	1922	270	269·00	99·63	3,687	25·00	14,401	3,139
	1923	304	285·00	93·75	3,896	25·00	15,577	3,586
	1924	304	297·00	97·70	4,219	24·00	18,111	4,339
	1925	317	317·00	100·00	4,434	24·00	19,683	4,586
	1926	**335**	**330·00**	**98·51**	**4,664**	**24·00**	**21,916**	**5,194**
B	1922*	414	332·33	80·27	5,588	21·68	14,804	—
	1923	422	333·36	79·00	5,816	20·71	15,365	4,979
	1924	427	355·26	83·20	6,479	19·77	15,773	5,179
	1925	427	390·00	91·33	6,869	20·61	15,169	5,455
	1926	**441**	**412·00**	**93·42**	**7,122**	**20·96**	**15,379**	**5,846**
C	1922	963	876·00	90·97	13,372	22·10	42,342	6,582
	1923	963	897·00	93·15	14,231	21·30	46,693	6,840
	1924	963	903·00	93·77	14,883	20·68	48,349	7,781
	1925	963	905·00	93·98	14,908	20·60	55,346	8,217
	1926	**994**	**905·00**	**91·05**	**16,138**	**19·03**	**56,089**	**9,174**
D	1922	665	657·90	98·93	10,809	21·10	44,689	8,613
	1923	665	722·90	108·72	12,106	20·70	48,693	10,062
	1924	664	726·60	109·43	13,297	19·00	51,954	9,522
	1925	664	740·70	111·55	14,187	18·20	55,276	10,853
	1926	**700**	**726·90**	**103·84**	**14,505**	**17·50**	**58,942**	**11,409**
E	1922	600	555·00	92·50	10,766	20·81	35,167	6,126
	1923	600	554·00	92·33	9,444	20·29	32,450	5,600
	1924	600	548·00	91·33	9,871	19·23	35,265	5,551
	1925	600	556·00	92·67	9,743	19·72	33,214	5,225
	1926	**600**	**564·00**	**94·00**	**10,579**	**18·53**	**34,438**	**6,166**
F	1922	260	286·00	110·00	3,950	25·90	9,881	2,025
	1923	260	288·00	110·77	4,223	24·40	11,843	1,987
	1924	260	294·00	113·08	4,167	25·00	12,937	2,245
	1925†	260	288·00	110·77	5,001	23·80	17,393	2,592
	1926	**260**	**288·00**	**110·77**	**4,615**	**21·70**	**16,039**	**2,450**
Total ..	1922	3,172	2,976·23	93·83	48,172		161,284	
	1923	3,214	3,080·26	95·84	49,716		170,621	33,092
	1924	3,218	3,123·86	97·07	52,916		182,389	34,617
	1925	3,231	3,196·70	98·94	55,142		196,081	36,928
	1926	**3,330**	**3,225·90**	**96·87**	**57,623**		**202,803**	**40,239**

* Year ended 15th May. † Period of 14 months.

NOTE :—Other Tables relating to the above Hospitals are Nos. 54, 59, 63 and 65.

SECTION 7.

INCOME AND EXPENDITURE ON MAINTENANCE ACCOUNT OF THE VOLUNTARY HOSPITALS IN SCOTLAND.

The financial position of the Scottish hospitals at the end of 1926 was more satisfactory than that of the English. In each group there was a considerable surplus of income available for the purpose of maintenance.

One of the features that distinguishes the Scottish hospitals from the English is that the large Medical School hospitals form the most, not, as further south, the least prosperous group of the General hospitals.

Tables 49, 50 and 51, if compared with Tables 55, 56 and 57, show how large a part extraordinary income, so called, plays in Scottish hospital finance. Extraordinary income forms almost a quarter of the total and increases the number of hospitals that end their year with a credit balance from 52 to 71.

In the Scottish A group hospitals (numbering 19 with a bed accommodation of 5,694) extraordinary income to the amount of £213,078, or more than a quarter of the total, was received. In the English and Welsh corresponding group (numbering 118 with a bed accommodation of 22,832), only £304,908, or not quite one-tenth of the total was received as extraordinary income. It is only in the C group that the relationship of extraordinary to ordinary income corresponds to the English standard of approximately £1 to £9.

TABLE 49.

INCOME AND EXPENDITURE ON MAINTENANCE ACCOUNT.

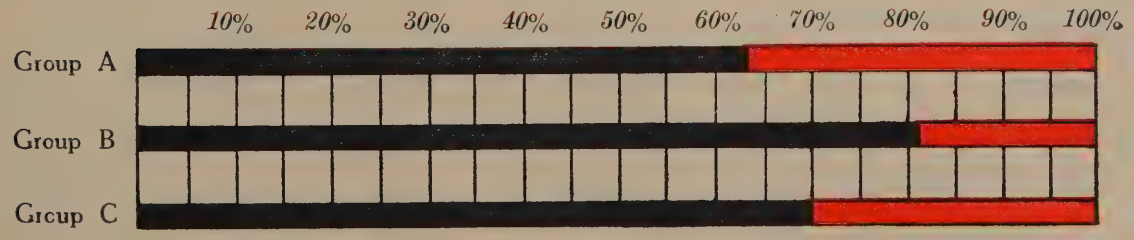
Hospitals.	No. of Hpls.	Income.			Expenditure.			Surplus.
		Ordinary.	Extra-ordinary.	Total.	Ordinary.	Extra-ordinary.	Total.	
Group A	19	£ 599,699	£ 213,078	£ 812,777	£ 706,346	£ 580	£ 706,926	£ 105,851
Group B	26	165,821	36,769	202,590	150,861	128	150,989	51,601
Group C	54	84,413	9,341	93,754	79,473	5	79,478	14,276
Total ..	**99**	**£ 849,933**	**£ 259,188**	**£ 1,109,121**	**£ 936,680**	**£ 713**	**£ 937,393**	**£ 171,728**

INCOME AND EXPENDITURE ON MAINTENANCE ACCOUNT.

PERCENTAGE OF HOSPITALS HAVING AN EXCESS OF:—

INCOME OVER EXPENDITURE . . . . . Shown in Black.

EXPENDITURE OVER INCOME . . . . . Shown in Red.



Illustrating Tables 50 and 51.

TABLE 50.

HOSPITALS HAVING AN EXCESS OF **INCOME OVER EXPENDITURE** ON MAINTENANCE ACCOUNT.

Hospitals.	No. of Hospitals.	Income. —			Expenditure.			Surplus.
		Ordinary.	Extra-ordinary.	Total Income available for maintenance	Ordinary	Extra-ordinary.	Total Expenditure on maintenance	
Group A ..	12 (63%)	£ 493,579	£ 206,954	£ 700,533	£ 577,509	£ 522	£ 578,031	£ 122,502
Group B ..	21 (81%)	143,936	36,441	180,377	125,289	124	125,413	54,964
Group C ..	38 (70%)	64,091	9,071	73,162	55,962	5	55,967	17,195
Total	**71 (72%)**	**£ 701,606**	**£ 252,466**	**£ 954,072**	**£ 758,760**	**£ 651**	**£ 759,411**	**£ 194,661**

TABLE 51.

HOSPITALS HAVING AN EXCESS OF **EXPENDITURE OVER INCOME** ON MAINTENANCE ACCOUNT.

Hospitals.	No. of Hospitals.	Income.			Expenditure.			Deficit.
		Ordinary.	Extra-ordinary.	Total Income available for maintenance	Ordinary	Extra-ordinary.	Total Expenditure on maintenance	
Group A ..	7 (37%)	£ 106,120	£ 6,124	£ 112,244	£ 128,837	£ 58	£ 128,895	£ 16,651
Group B ..	5 (19%)	21,885	328	22,213	25,572	4	25,576	3,363
Group C ..	16 (30%)	20,322	270	20,592	23,511	—	23,511	2,919
Total	**28 (28%)**	**£ 148,327**	**£ 6,722**	**£ 155,049**	**£ 177,920**	**£ 62**	**£ 177,982**	**£ 22,933**

TABLE 52.

INCOME AND EXPENDITURE ON MAINTENANCE ACCOUNT PER AVAILABLE BED.

Hospitals.	No. of Hospitals.	No. of available beds.	Per *available* bed. †		
			Income.	Expenditure.	Surplus.
Group A	19	5,694	£ 143	£ 124	£ 19
Group B	26	1,428	142	106	36
Group C	54	916	102	87	15
Total	**99**	**£ 8,038**	**£ 138**	**£ 117**	**£ 21**

† Calculated to the nearest £.

; GRAND PRIORY IN THE BRITISH REALM OF
'HE VENERABLE ORDER OF THE
SPITAL OF ST. JOHN OF JERUSALEM

Grand Prior—
Field-Marshal His Royal Highness
The Duke of Connaught K.G., K.T., K.P.

THE
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HOSPITAL AND MEDICAL SERVICES DEPARTMENT.

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19, BERKELEY STREET,
LONDON, W.1.

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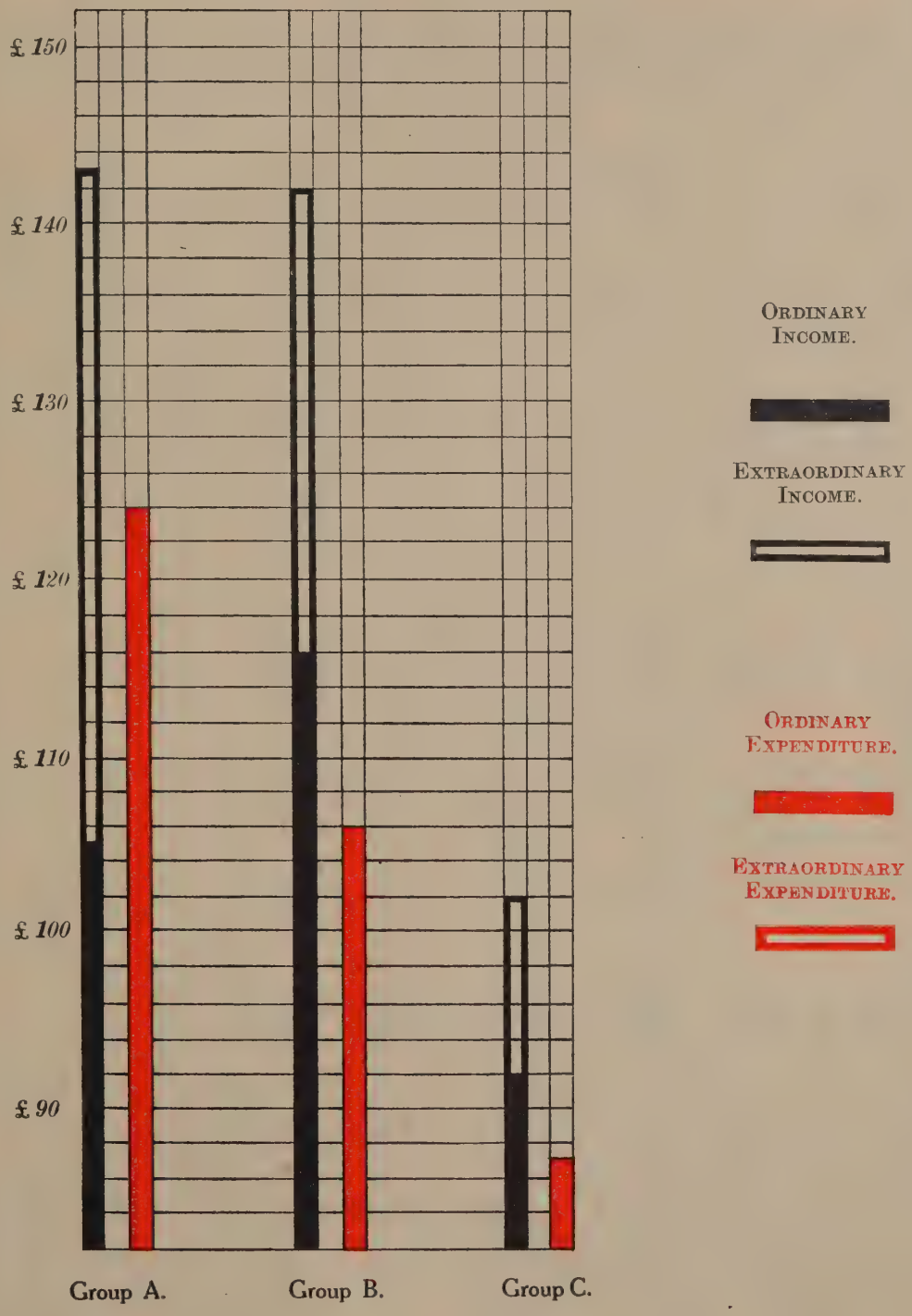
INCOME AND EXPENDITURE ON MAINTENANCE ACCOUNT PER AVAILABLE BED.



Illustrating Tables 52 and 58.

TABLE 53.

INCOME AND EXPENDITURE ON MAINTENANCE ACCOUNT OF GENERAL AND SPECIAL HOSPITALS SHOWN SEPARATELY.

Hospitals.	No. of Hpls.	No. of available beds.	Income.			Expenditure.			Per *available* bed. †			
			Ordinary.	Extra-ordinary.	Total Income available for Maintenance.	Ordinary	Extra-ordinary.	Total Expenditure on Maintenance.	Income.	Expen-diture.	Deficit.	Surplus.
General Hospitals—												
Group A—												
Medical School Hospitals	*6*	*3,330*	£ *383,860*	£ *179,283*	£ *563,143*	£ *452,953*	£ *195*	£ *453,148*	£ *169*	£ *136*	—	£ *33*
		* *352*	*14,423*	*380*	*14,803*	*18,574*	*115*	*18,689*	*42*	*53*	£ *11*	—
	6	3,682	398,283	179,663	577,946	471,527	310	471,837	157	128	—	29
Hospitals without Medical Schools	*9*	*1,286*	*113,770*	*21,965*	*135,735*	*132,778*	*50*	*132,828*	*106*	*103*	—	*3*
		* *11*	*180*	—	*180*	*521*	—	*521*	*16*	*47*	*31*	—
	9	1,297	113,950	21,965	135,915	133,299	50	133,349	105	103	—	2
Group B	*15*	*738*	*77,058*	*9,963*	*87,021*	*73,824*	*4*	*73,828*	*118*	*100*	—	*18*
		* *56*	*1,424*	*180*	*1,604*	*1,818*	—	*1,818*	*29*	*32*	*3*	—
	15	794	78,482	10,143	88,625	75,642	4	75,646	112	95	—	17
Group C	46	768	69,503	8,833	78,336	66,164	5	66,169	102	86	—	16
Totals of General Hospitals	*76*	*6,122*	£ *644,191*	£ *220,044*	£ *864,235*	£ *725,719*	£ *254*	£ *725,973*	£*141*	£ *119*	—	£ *22*
		* *419*	*16,027*	*560*	*16,587*	*20,913*	*115*	*21,028*	*40*	*50*	£ *10*	—
	76	**6,541**	**660,218**	**220,604**	**880,822**	**746,632**	**369**	**747,001**	**135**	**114**	—	**21**
Special Hospitals—												
Group A	*4*	*658*	£ *86,829*	£ *11,450*	£ *98,279*	£ *97,767*	£ *220*	£ *97,987*	£ *149*	£ *149*	—	—
		* *57*	*637*	—	*637*	*3,753*	—	*3,753*	*11*	*66*	£ *55*	—
	4	715	87,466	11,450	98,916	101,520	220	101,740	138	142	4	—
Group B	11	634	87,339	26,626	113,965	75,219	124	75,343	180	119	—	£ 61
Group C	8	148	14,910	508	15,418	13,309	—	13,309	104	90	—	14
Totals of Special Hospitals	*23*	*1,440*	£ *189,078*	£ *38,584*	£ *227,662*	£ *186,295*	£ *344*	£ *186,639*	£ *158*	£ *130*	—	£ *28*
		* *57*	*637*	—	*637*	*3,753*	—	*3,753*	*11*	*66*	£ *55*	—
	23	**1,497**	**189,715**	**38,584**	**228,299**	**190,048**	**344**	**190,392**	**153**	**127**	—	**26**

† Calculated to the nearest £.

* Figures relating to Auxiliary Hospitals and Convalescent Homes under the control of the Hospitals.

Table 54, if compared with Table 16, brings out this striking difference between the hospitals north and south of the Tweed. In every case the Scottish Medical School hospitals received more than one quarter of their income from " Extraordinary " sources. In not more than two of the English hospitals in the corresponding group did " Extraordinary " reach one-eighth of the total income.

TABLE 54.

INCOME AND EXPENDITURE ON MAINTENANCE ACCOUNT OF THE SIX HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN SCOTLAND.

Hospitals.	Income.			Expenditure.			Per *occupied* bed.		
	Ordinary.	Extra-ordinary.	Total Income available for Maintenance.	Ordinary.	Extra-ordinary.	Total Expenditure on Maintenance.	Income.	Expen-diture.	Surplus.
A	£ 31,883	£ 10,904	£ 42,787	£ 32,277	—	£ 32,277	£ 129·66	£ 97·81	£ 31·85
B	38,555	30,441	68,996	43,652	—	43,652	167·47	105·95	61·52
C	112,656	48,737	161,393	129,901	£ 195	130,096	178·33	143·75	34·58
D	83,950	38,635	122,585	118,985	—	118,985	168·64	163·69	4·95
E	68,538	27,924	96,462	82,119	—	82,119	171·03	145·60	25·43
F	48,278	22,642	70,920	46,019	—	46,019	246·25	159·79	86·46
Total	£ 383,860	£ 179,283	£ 563,143	£ 452,953	£ 195	£ 453,148	£ 174·57	£ 140·47	£ 34·10

NOTE.—Other Tables relating to the above Hospitals are Nos. 48, 59, 63 and 65.

TABLE 55.

ORDINARY INCOME AND EXPENDITURE.

Hospitals.	Year.	No. of Hospitals	Total Ordinary Income.	Total Ordinary Expenditure.	Deficit.	Surplus.
Group A	1922	18	£ 563,302	£ 631,437	£ 68,135	—
	1923	19	561,243	644,420	83,177	—
	1924	19	595,948	674,833	78,885	—
	1925	19	632,441	675,809	43,368	—
	1926	**19**	**599,699**	**706,346**	**106,647**	—
Group B	1922	20	123,507	114,259	—	£ 9,248
	1923	20	127,451	111,096	—	16,355
	1924	21	137,156	121,931	—	15,225
	1925	26	156,418	138,335	—	18,083
	1926	**26**	**165,821**	**150,861**	—	**14,960**
Group C	1922	41	63,657	58,981	—	4,676
	1923	47	76,853	66,049	—	10,804
	1924	53	81,788	72,610	—	9,178
	1925	50	76,458	68,570	—	7,888
	1926	**54**	**84,413**	**79,473**	—	**4,940**
Total	1922	79	£ 750,466	£ 804,677	£ 54,211	—
	1923	86	765,547	821,565	56,018	—
	1924	93	814,892	869,374	54,482	—
	1925	95	865,317	882,714	17,397	—
	1926	**99**	**849,933**	**936,680**	**86,747**	—

TABLE 56.

HOSPITALS HAVING AN **EXCESS OF ORDINARY INCOME** OVER ORDINARY EXPENDITURE.

Hospitals.	Year.	No. of Hospitals.	Total Ordinary Income.	Total Ordinary Expenditure.	Surplus.
Group A	1922	4 (22%)	£ 55,661	£ 50,538	£ 5,123
	1923	1 (5%)	5,775	5,632	143
	1924	3 (16%)	156,235	154,628	1,607
	1925	5 (26%)	139,005	123,686	15,319
	1926	**2 (11%)**	**78,999**	**78,005**	**994**
Group B	1922	11 (55%)	73,130	58,821	14,309
	1923	16 (80%)	106,739	87,863	18,876
	1924	14 (67%)	99,940	81,579	18,361
	1925	18 (69%)	124,527	102,657	21,870
	1926	**17 (65%)**	**108,432**	**87,256**	**21,176**
Group C	1922	27 (66%)	40,886	33,058	7,828
	1923	36 (77%)	63,129	49,802	13,327
	1924	33 (62%)	54,293	39,067	15,226
	1925	35 (70%)	55,525	44,761	10,764
	1926	**33 (61%)**	**57,407**	**48,987**	**8,420**
Total	1922	42 (53%)	£ 169,677	£ 142,417	£ 27,260
	1923	53 (62%)	175,643	143,297	32,346
	1924	50 (54%)	310,468	275,274	35,194
	1925	58 (61%)	319,057	271,104	47,953
	1926	**52 (53%)**	**244,838**	**214,248**	**30,590**

TABLE 57.

HOSPITALS HAVING AN **EXCESS OF ORDINARY EXPENDITURE** OVER ORDINARY INCOME.

Hospitals.	Year.	No. of Hospitals.	Total Ordinary Income.	Total Ordinary Expenditure.	Deficit.
Group A	1922	14 (78%)	£ 507,641	£ 580,899	£ 73,258
	1923	18 (95%)	555,468	638,788	83,320
	1924	16 (84%)	439,713	520,205	80,492
	1925	14 (74%)	493,436	552,123	58,687
	1926	**17 (89%)**	**520,700**	**628,341**	**107,641**
Group B	1922	9 (45%)	50,377	55,438	5,061
	1923	4 (20%)	20,712	23,233	2,521
	1924	7 (33%)	37,216	40,352	3,136
	1925	8 (31%)	31,891	35,678	3,787
	1926	**9 (35%)**	**57,389**	**63,605**	**6,216**
Group C	1922	14 (34%)	22,771	25,923	3,152
	1923	11 (23%)	13,724	16,247	2,523
	1924	20 (38%)	27,495	33,543	6,048
	1925	15 (30%)	20,933	23,809	2,876
	1926	**21 (39%)**	**27,006**	**30,486**	**3,480**
Total	1922	37 (47%)	£ 580,789	£ 662,260	£ 81,471
	1923	33 (38%)	589,904	678,268	88,364
	1924	43 (46%)	504,424	594,100	89,676
	1925	37 (39%)	546,260	611,610	65,350
	1926	**47 (47%)**	**605,095**	**722,432**	**117,337**

TABLE 58.

ORDINARY INCOME AND EXPENDITURE PER AVAILABLE BED.

Hospitals.	Year.	No. of Hospitals.	No. of available beds.	Ordinary Income per *available* bed.*	Ordinary Expenditure per *available* bed.*	Surplus.*	Deficit.*
Group A	1922	18	5,316	£ 106	£ 119	—	£ 13
	1923	19	5,435	103	119	—	16
	1924	19	5,495	108	123	—	15
	1925	19	5,532	114	122	—	8
	1926	**19**	**5,694**	**105**	**124**	—	**19**
Group B	1922	20	1,152	107	99	£ 8	—
	1923	20	1,149	111	97	14	—
	1924	21	1,244	110	98	12	—
	1925	26	1,389	113	100	13	—
	1926	**26**	**1,428**	**116**	**106**	**10**	—
Group C	1922	41	607	105	97	8	—
	1923	47	742	104	89	15	—
	1924	53	844	97	86	11	—
	1925	50	811	94	85	9	—
	1926	**54**	**916**	**92**	**87**	**5**	—
Total ..	1922	79	7,075	£ 106	£ 114	—	£ 8
	1923	86	7,326	104	112	—	8
	1924	93	7,583	107	115	—	8
	1925	95	7,732	112	114	—	2
	1926	**99**	**8,038**	**106**	**117**	—	**11**

* Calculated to the nearest £.

TABLE 59.

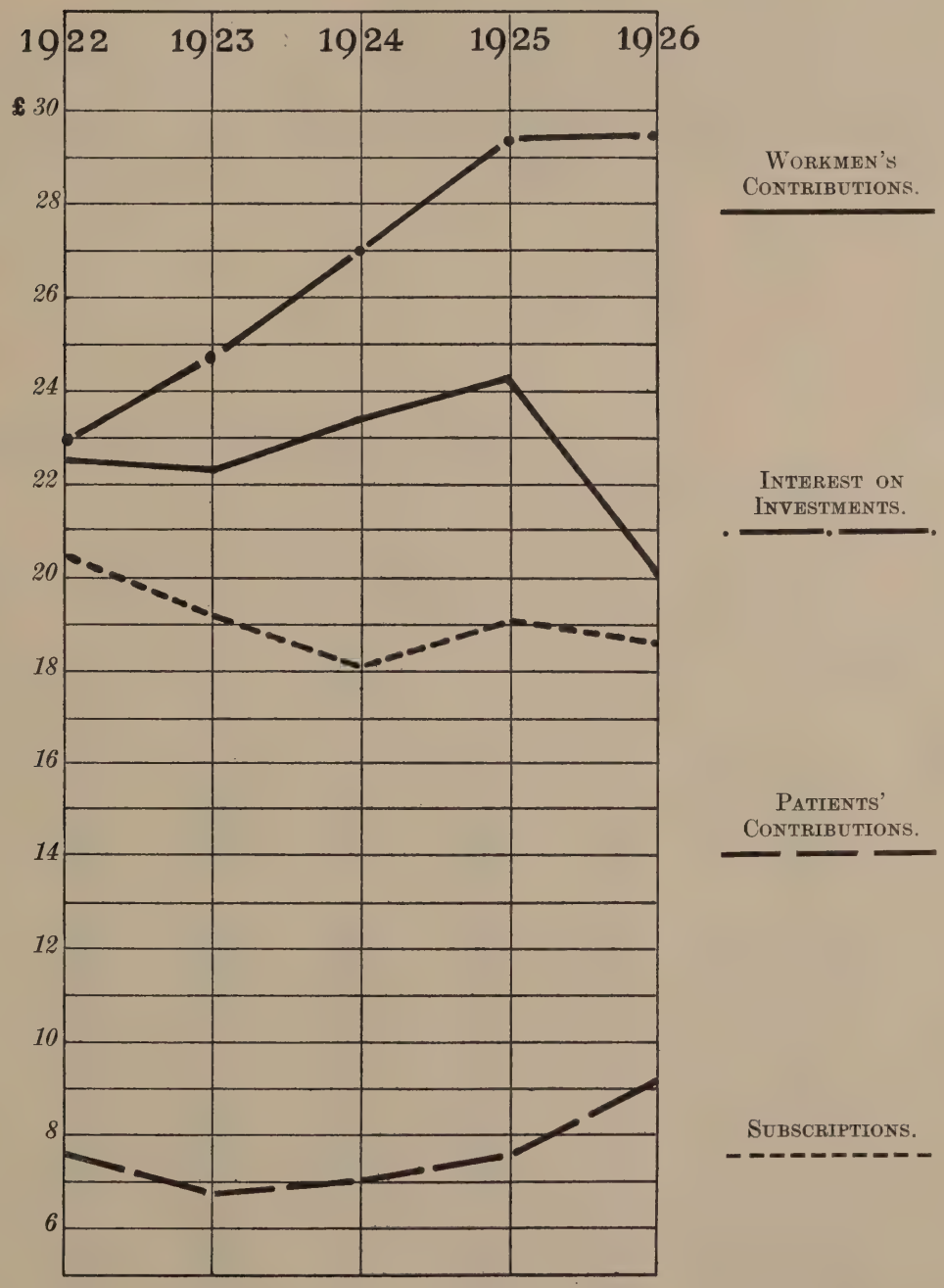
ORDINARY INCOME AND EXPENDITURE OF THE SIX HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN SCOTLAND.

Hospital.	Year.	Ordinary Income.	Ordinary Expenditure.	Ordinary Income per *occupied* bed.	Ordinary Expenditre per *occupied* bed.	Per *occupied* bed.	
						Deficit.	Surplus.
A	1922	£ 27,130	£ 29,572	£ 100·85	£ 109·93	£ 9·08	—
	1923	28,404	29,963	99·66	105·13	5·47	—
	1924	29,173	29,923	98·23	100·75	2·52	—
	1925	31,869	30,948	100·53	97·63	—	£ 2·90
	1926	**31,883**	**32,277**	**96·61**	**97·81**	**1·20**	—
B	1922*	35,286	37,042	106·18	111·46	5·28	—
	1923	26,852	36,291	80·55	108·86	28·31	—
	1924	31,805	36,267	89·53	102·09	12·56	—
	1925	37,393	39,802	95·88	102·06	6·18	—
	1926	**38,555**	**43,652**	**93·58**	**105·95**	**12·37**	—
C	1922	105,878	119,759	120·84	136·71	15·87	—
	1923	116,509	119,810	129·89	133·57	3.68	—
	1924	113,915	127,537	126·15	141·24	15·09	—
	1925	114,896	127,751	126·96	141·16	14·20	—
	1926	**112,656**	**129,901**	**124·48**	**143·54**	**19·06**	—
D	1922	101,315	104,813	154·00	159·31	5·31	—
	1923	94,176	107,598	130·28	148·84	18·56	—
	1924	108,469	110,194	149·28	151·66	2.38	—
	1925	94,157	111,452	127·12	150·47	23·35	—
	1926	**83,950**	**118,985**	**115·49**	**163·69**	**48·20**	—
E	1922	68,348	88,534	123·14	159·05	35.91	—
	1923	68,418	84,352	123·50	152·26	28·76	—
	1924	69,784	97,537	127·34	177·99	50·65	—
	1925	75,114	77,595	135·10	139·56	4·46	—
	1926	**68,538**	**82,119**	**121·52**	**145·60**	**24·08**	—
F	1922	43,636	42,635	152·57	149·07	—	3·50
	1923	41,261	42,669	143·27	148·16	4.89	—
	1924	42,250	44,133	143·71	150·11	6·40	—
	1925†	61,290	52,279	212·81	181·52	—	31·29
	1926	**48,278**	**46,019**	**167·63**	**159·79**	—	**7·84**
Total ..	1922	£ 381,593	£ 422,355	£ 128·21	£ 141·90	£ 13·69	—
	1923	375,620	420,683	121·94	136·57	14·63	—
	1924	395,396	445,591	126·57	142·64	16·07	—
	1925	414,719	439,827	129·73	137·59	7·86	—
	1926	**383,860**	**452,953**	**118·99**	**140·41**	**21·42**	—

* Year ended 15th May. † Period of 14 months.

NOTE :—Other Tables relating to the above Hospitals are Nos. 48, 54, 63 and 65.

ANALYSIS OF ORDINARY INCOME PER AVAILABLE BED OF THE TOTAL NUMBER OF HOSPITALS REVIEWED.



Illustrating Table 60.

ANALYSIS OF SOME OF TH
INCOME OF THE VOLUNTAR

Table 60. The following short comparison between the Scottish and English hospitals shows that the industrial conditions during 1926 hit the Scottish rather more severely than the English. The reduction in the voluntary gifts of nearly £8 per available bed will be found mainly under the headings "Donations" and "Workmen's Contributions."

TABLE 60

ANALYSIS OF THE PRINCIPAL ITEMS OF ORDINARY

Hospitals.	Year.	No. of Hospitals.	No. of available beds.	Investments.		Voluntary			
				Interest from Investments.		Subscriptions.		Donations (including Entertainments, etc.)	
				Total.	Amount per available bed	Total.	Amount per available bed	Total.	Amount per available bed
Group A ..	1922	18	5,316	£ 119,457	£ *22·47*	£ 105,129	£ 19·78	£ 90,941	£ 17·11
	1923	19	5,435	131,625	*24·22*	101,855	18·74	82,124	15·11
	1924	19	5,495	147,911	*26·92*	102,143	18·59	99,489	18·11
	1925	19	5,532	166,368	*30·07*	107,773	19·48	104,083	18·81
	1926	**19**	**5,694**	**168,915**	**29·67**	**105,102**	**18·46**	**89,622**	**15·74**
Group B ..	1922	20	1,152	26,532	*23·03*	25,816	22·41	15,573	13·52
	1923	20	1,149	29,327	*25·24*	23,378	20·35	21,985	19·13
	1924	21	1,244	36,171	*29·08*	18,100	14·55	22,348	17·96
	1925	26	1,389	41,790	*30·09*	23,248	16·74	29,261	21·07
	1926	**26**	**1,428**	**43,595**	**30·53**	**26,862**	**18·81**	**28,754**	**20·14**
Group C ..	1922	41	607	16,803	*27·68*	13,902	22·90	8,599	14·17
	1923	47	742	21,551	*29·04*	15,561	20·97	12,070	16·27
	1924	53	844	21,768	*25·79*	16,981	20·12	14,575	17·27
	1925	50	811	20,006	*24·67*	16,712	20·61	14,244	17·56
	1926	**54**	**916**	**25,292**	**27·61**	**18,208**	**19·88**	**12,488**	**13·63**
Total	1922	79	7,075	£ 162,792	£ *23·01*	£ 144,847	£ 20·47	£ 115,113	£ 16·27
	1923	86	7,326	182,503	*24·91*	140,794	19·20	116,179	15·86
	1924	93	7,583	205,850	*27·14*	137,224	18·10	136,412	17·99
	1925	95	7,732	228,164	*29 51*	147,733	19·11	147,588	19·09
	1926	**99**	**8,038**	**237,802**	**29·58**	**150,172**	**18·68**	**130,864**	**16·28**

OURCES OF ORDINARY
IOSPITALS IN SCOTLAND.

	Amount per available bed.			
	English.		Scottish.	
	1925.	1926.	1925.	1926.
Investments	£ 19·16	£ 19·20	£ 29·51	£ 29·58
Voluntary Gifts	79·76	74·46	66·23	58·53
Receipts for Services rendered	27·22	27·93	13·62	15·36

INCOME—HOSPITALS GROUPED ACCORDING TO SIZE.

Gifts.					Receipts for Services Rendered.					
Workmen's Contributions, Hospital Saturday Funds, and Contributory Schemes		Congregational Collection.		Total of Voluntary Gifts per available bed.	Patients' Contributions.		Public Services.		Total Earnings per available bed.	Total per available bed from the seven sources.
Total.	Amount per available bed	Total.	Amount per available bed		Total.	Amount per available bed	Total.	Amount per available bed.		
£ 139,845	£ 26·31	£ 21,776	£ 4·10	£ *67·30*	£ 28,468	£ 5.36	£ 28,523	£ 5·37	£ *10 73*	£ 100·50
138,898	25·56	23,424	4·31	*63·72*	22,251	4·09	40,537	7·46	*11 55*	99·49
145,435	26·47	20,172	3·67	*66·84*	24,215	4·41	37,123	6·76	*11·17*	104·93
152,266	27·52	23,623	4·27	*70·08*	27,800	5·03	35,194	6·36	*11·39*	111·54
131,162	**23·04**	**22,508**	**3·95**	**61·19**	**30,248**	**5·31**	**37,810**	**6·64**	**11·95**	**102·81**
12,995	11·28	930	0·81	*48·02*	16,652	14·45	12,144	10·54	*24·99*	96·04
14,643	12·74	1,567	1·36	*53·58*	17,417	15·16	13,894	12·09	*27·25*	106·07
22,529	18·11	1,954	1·57	*52·19*	16,588	13·33	14,942	12·01	*25·34*	106·61
25,398	18·29	2,889	2·08	*58·18*	20,023	14·42	8,665	6·24	*20·66*	108 93
24,273	**17·00**	**2,541**	**1·78**	**57·73**	**26,937**	**18·86**	**9,208**	**6·45**	**25·31**	**113·57**
6,973	11·49	1,261	2·08	*50·64*	8,648	14·25	2,880	4·74	*18·99*	97·31
10,692	14·41	1,326	1·80	*53·45*	10,501	14·15	2,224	3·00	*17·15*	99·64
10,220	12·11	1,302	1·54	*51·04*	12,672	15·01	2,605	3·09	*18·10*	94·93
11,157	13·76	1,362	1·68	*53·61*	10,904	13·45	2,704	3·33	*16·78*	95·06
7,383	**8·06**	**1,568**	**1·71**	**43·28**	**16,433**	**17·94**	**2,834**	**3·09**	**21·03**	**91·92**
£ 159,813	£ 22·59	£ 23,967	£ 3·39	£ *62·72*	£ 53,768	£ 7·60	£ 43,547	£ 6·16	£ *13·76*	£ 99 49
164,233	22·42	26,317	3·59	*61·07*	50,169	6.85	56,655	7·73	*14·58*	100·56
178,184	23·50	23,428	3·09	*62·68*	53,475	7·05	54,670	7·21	*14·26*	104·08
188,821	24·42	27,874	3·61	*66·23*	58,727	7·60	46,563	6·02	*13·62*	109 36
162,818	**20·26**	**26,617**	**3·31**	**58·53**	**73,618**	**9·16**	**49,852**	**6·20**	**15·36**	**103·47**

TABLE 61.

INVESTED FUNDS.

Hospitals.	Year.	No. of Hospitals.	No. of available beds.	Invested Funds.	
				Total.	Per *available* bed.
Group A	1922	18	5,316	£ 2,473,707	£ 465
	1923	19	5,435	2,720,189	500
	1924	19	5,495	3,206,507	584
	1925	19	5,532	3,422,382	619
	1926	**19**	**5,694**	**3,549,376**	**623**
Group B	1922	20	1,152	547,392	475
	1923	20	1,149	669,600	583
	1924	21	1,244	864,684	695
	1925	26	1,389	1,016,625	732
	1926	**26**	**1,428**	**1,026,935**	**719**
Group C	1922	41	607	357,502	589
	1923	47	742	480,613	648
	1924	53	844	494,459	586
	1925	50	811	437,485	539
	1926	**54**	**916**	**540,456**	**590**
Total	1922	79	7,075	£ 3,378,601	£ 478
	1923	86	7,326	3,870,402	528
	1924	93	7,583	4,565,650	602
	1925	95	7,732	4,876,492	631
	1926	**99**	**8,038**	**5,116,767**	**637**

TABLE 62.

ANALYSIS OF THE SOURCES OF INCOME FROM PUBLIC SERVICES.

Hospitals.	Year.	War Office or Admiralty.	Ministry of Pensions.	Infant Welfare & Maternity Work.	Venereal Diseases.	Tuber-culosis Cases.	Education Authori-ties.	National Health Insurance Act.	Details not given.
Group A ..	1922	—	£ 7,679	£ 5,166	£ 9,442	£ 512	£ 8	£ 4,665	£ 1,051
	1923	—	989	3,210	9,765	787	14	7,757	18,015
	1924	£ 27	621	4,717	7,690	659	15	10,651	12,743
	1925	48	923	5,125	13,840	609	—	10,484	4,165
	1926	**300**	**711**	**7,411**	**13,294**	**530**	—	**11,448**	**4,116**
Group B ..	1922	74	626	522	8,049	2,130	105	178	[460
	1923	—	362	2,122	7,848	2,299	—	651	612
	1924	—	254	2,286	6,599	2,692	18	696	2,397
	1925	—	117	3,245	1,736	349	67	585	2,566
	1926	—	**8**	**3,432**	**1,603**	**105**	**187**	**1,025**	**2,848**
Group C ..	1922	—	156	807	—	604	34	15	1,264
	1923	—	46	720	—	5	61	[120	1,272
	1924	—	7	451	—	139	146	503	1,359
	1925	—	—	90	—	89	155	229	2,141
	926	**6**	**6**	**156**	—	**79**	**202**	**342**	**2,043**
Total	1922	£ 74	£ 8,461	£ 6,495	£ 17,491	£ 3,246	£ 147	£ 4,858	£ 2,775
	1923	—	1,397	6,052	17,613	3,091	75	8,528	19,899
	1924	27	882	7,454	14,289	3,490	179	11,850	16,499
	1925	48	1,040	8,460	15,576	1,047	222	11,298	8,872
	1926	**306**	**725**	**10,999**	**14,897**	**714**	**389**	**12,815**	**9,007**

TABLE 63.

SOME OF THE SOURCES OF ORDINARY INCOME OF THE SIX HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN SCOTLAND.

Hospital.	Year.	Interest on Investments.	Workmen's Contributions, Hospital Saturday Funds and Contributory Schemes.	Patients' Contributions.	Income from Public Services.
A	1922	£ 6,526	£ 3,437	£ 1,543	£ 2,733
	1923	6,811	3,413	1,611	4,274
	1924	7,130	3,843	1,960	3,637
	1925	7,699	3,865	2,274	3,761
	1926	**8,773**	**3,744**	**2,162**	**4,362**
B	1922*	9,948	4,670	6,315	—
	1923	9,602	4,693	1,347	—
	1924	9,880	5,420	1,787	2,007
	1925	9,570	6,074	3,144	2,240
	1926	**9,877**	**5,747**	**3,206**	**2,713**
C	1922	21,065	34,294	2,602	5,769
	1923	21,864	37,416	1,873	13,553
	1924	23,427	37,950	2,155	9,288
	1925	24,693	36,827	2,924	8,175
	1926	**29,313**	**32,726**	**3,455**	**8,350**
D	1922	14,690	29,030	2,539	3,061
	1923	16,939	28,953	2,033	3,071
	1924	18,026	29,971	1,875	4,526
	1925	23,317	28,903	1,698	2,934
	1926	**23,118**	**25,014**	**1,486**	**1,190**
E	1922	10,304	25,691	2,060	3,528
	1923	12,784	21,115	1,758	5,792
	1924	16,550	23,161	1,451	4,150
	1925	19,005	23,641	1,498	3,508
	1926	**18,528**	**20,649**	**1,445**	**4,315**
F	1922	10,391	12,121	352	926
	1923	13,181	10,247	949	526
	1924	15,750	10,384	393	—
	1925†	22,352	16,491	1,259	497
	1926	**19,888**	**10,551**	**402**	**260**
Total	1922	£ 72,924	£ 109,243	£ 15,411	£ 16,017
	1923	81,181	105,837	9,571	27,216
	1924	90,763	110,729	9,621	23,608
	1925	106,636	115,801	12,797	21,115
	1926	**109,497**	**98,431**	**12,156**	**21,190**

* Year ended 15th May. † Period of 14 months.

NOTE:—Other Tables relating to the above Hospitals are Nos. 48, 54, 59 and 65.

ANALYSIS OF THE PRINCIPAL EXPENDITURE OF THE VOLUNTARY

Table 66 shows that Coal, Coke, Gas and Electricity cost £3 more per available bed in 1926 than in 1925. Save for this increase, the four main items of hospital expenditure in 1926, as given in Table 64, show little change from the preceding year.

TABLE 64.

ANALYSIS OF THE PRINCIPAL ITEMS OF

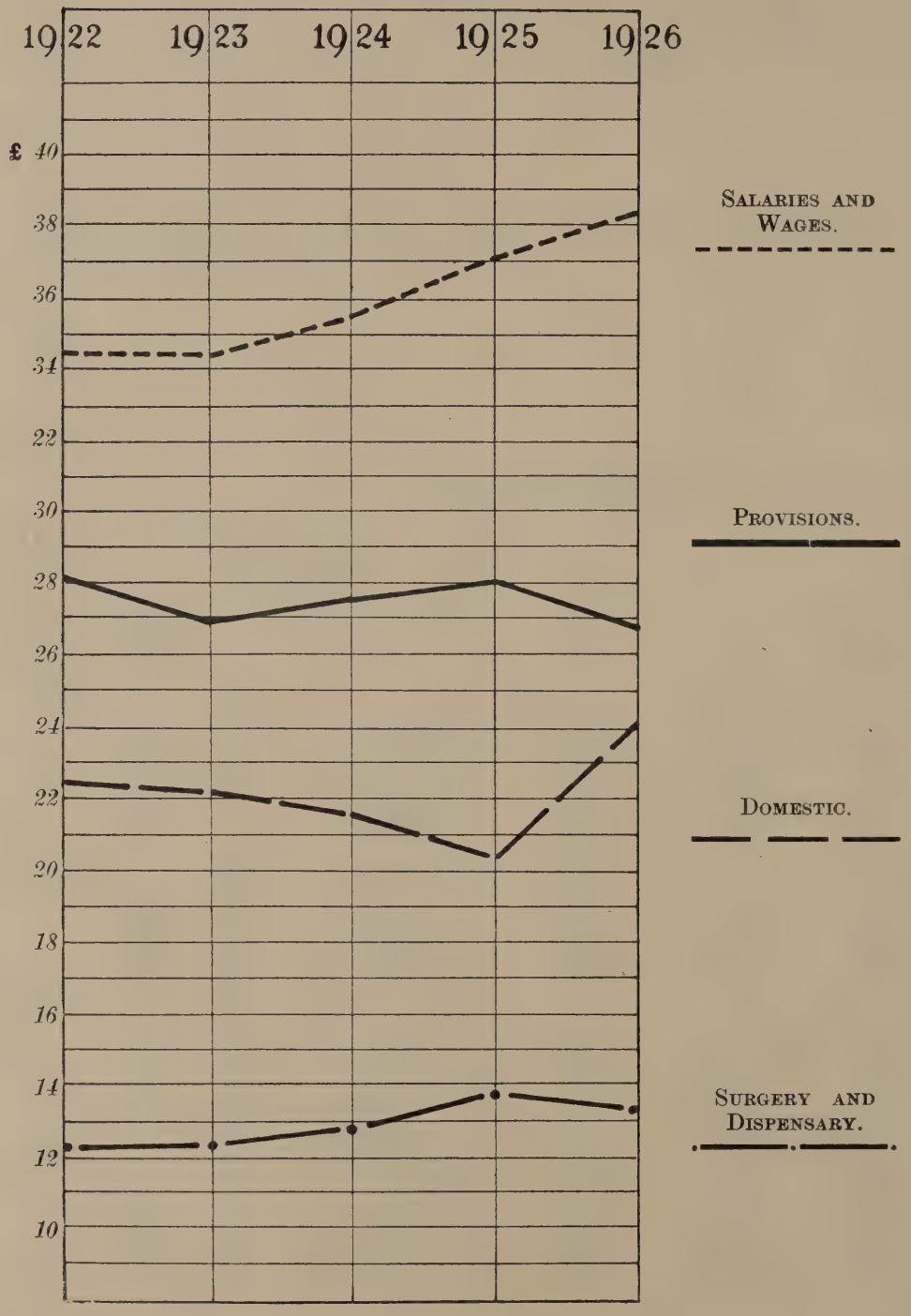
Hospitals.	Year.	No. of Hospitals giving details.	No. of available beds.	Provisions.		Surgery and Dispensary.	
				Total.	Per *available* bed.	Total.	Per *available* bed.
Group A ..	1922	18	5,316	£ 153,294	£ 28·84	£ 69,451	£ 13·06
	1923	19	5,435	151,811	27·93	72,605	13·36
	1924	19	5,495	157,595	28·68	77,508	14·11
	1925	19	5,532	162,811	29·43	83,241	15·05
	1926	**19**	**5,694**	**156,967**	**27·57**	**82,888**	**14·56**
Group B ..	1922	19	1,068	27,813	26·04	11,033	10·33
	1923	19	1,065	26,265	24·66	11,244	10·56
	1924	18	1,056	26,463	25·06	12,081	11·44
	1925	24	1,281	31,742	24·78	15,103	11·79
	1926	**23**	**1,280**	**32,979**	**25·76**	**15,449**	**12·07**
Group C ..	1922	31	493	12,558	25·47	3,848	7·81
	1923	36	610	14,274	23·40	4,232	6·94
	1924	42	680	16,093	23·67	4,286	6·30
	1925	40	635	14,449	22·76	4,770	7·51
	1926	**44**	**738**	**17,255**	**23·38**	**4,921**	**6·67**
Total	1922	68	6,877	£ 193,665	£ 28·16	£ 84,332	£ 12·26
	1923	74	7,110	192,350	27·05	88,081	12·39
	1924	79	7,231	200,151	27·68	93,875	12·98
	1925	83	7,448	209,002	28·06	103,114	13·84
	1926	**86**	**7,712**	**207,201**	**26·87**	**103,258**	**13·39**

ITEMS OF ORDINARY
HOSPITALS IN SCOTLAND.

ORDINARY EXPENDITURE BY GROUP AVERAGES

Domestic.		Salaries and Wages.		Total Expenditure under the four headings.	
Total.	Per *available* bed.	Total.	Per *available* bed.	Total.	Per *available* bed.
£ 120,174	£ 22·61	£ 194,522	£ 36·59	£ 537,441	£ 101·10
118,615	21·82	201,335	37·05	544,366	100·16
118,463	21·56	209,920	38·20	563,486	102·55
111,191	20·10	220,771	39·91	578,014	104·49
137,510	**24·15**	**232,297**	**40·80**	**609,662**	**107·08**
24,703	23·13	28,708	26·88	92,257	86·38
27,344	25·68	27,779	26·08	92,632	86·98
26,361	24·96	29,684	28·11	94,589	89·57
31,099	24·28	38,046	29·70	115,990	90·55
36,057	**28·17**	**41,376**	**32·32**	**125,861**	**98·32**
10,550	21·40	14,388	29·18	41,344	83·86
11,990	19·66	16,234	26·61	46,730	76·61
12,468	18·34	17,904	26·33	50,751	74·64
10,733	16·90	17,280	27·21	47,232	74·38
13,159	**17·83**	**21,722**	**29·43**	**57,057**	**77·31**
£ 155,427	£ 22·60	£ 237,618	£ 34·55	£ 671,042	£ 97·57
157,949	22·21	245,348	34·51	683,728	96·16
157,292	21·75	257,508	35·62	708.826	98·03
153,023	20·55	276,097	37·07	741.236	99·52
186,726	**24·21**	**295,395**	**38·30**	**792,580**	**102·77**

ANALYSIS OF ORDINARY EXPENDITURE PER AVAILABLE BED OF THE TOTAL NUMBER OF HOSPITALS REVIEWED.



Illustrating Table 64.

TABLE 65.

ANALYSIS OF THE PRINCIPAL ITEMS OF ORDINARY EXPENDITURE IN THE SIX HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN SCOTLAND.

Hospital.	Year.	Average No. of beds. occupied daily.	Provisions.		Surgery and Dispensary.		Domestic.		Salaries and Wages.	
			Total.	Per *occupied* bed.	Total.	Per *occupied* bed.	Total.	Per *occupied* bed.	Total.	Per *occupied* bed.
A ..	1922	269·00	£ 6,949	£ 25·8	£ 3,369	£ 12·5	£ 5,956	£ 22·2	£ 8,894	£ 33·1
	1923	285·00	7,184	25·2	3,810	13·4	6,081	21·3	8,997	31·6
	1924	297·00	7,226	24·3	3,604	12·1	6,282	21·2	9,282	31·3
	1925	317·00	7,795	24·6	3,781	11·9	6,047	19·1	9,566	30·2
	1926	**330·00**	**7,992**	**24·22**	**3,934**	**11·92**	**6,914**	**20·95**	**9,878**	**29·93**
B ..	1922*	332·33	9,606	28·9	4,568	13·7	8,959	27·0	10,472	31·5
	1923	333·36	8,125	24·4	3,618	10·9	7,550	22·6	11,991	36·0
	1924	355·26	8,495	23·9	3,616	10·2	6,330	18·1	13,055	36·7
	1925	390·00	9,661	25·5	4,550	11·7	6,251	16·0	13,756	35·3
	1926	**412·00**	**9,631**	**23·38**	**4,788**	**11·62**	**8,097**	**19·65**	**15,355**	**37·27**
C ..	1922	876·00	24,150	27·6	12,810	14·6	20,189	23·0	41,677	47·6
	1923	897·00	22,761	25·4	14,209	15·8	18,904	21·1	41,390	46·1
	1924	903·00	24,402	27·0	16,547	18·3	19,774	21·9	44,632	49·4
	1925	905·00	24,863	27·5	15,468	17·1	20,782	23·0	47,285	52·2
	1926	**905·00**	**24,429**	**26·99**	**15,879**	**17·55**	**21,059**	**23·27**	**49,544**	**54·74**
D ..	1922	657·90	28,872	43·9	12,784	19·4	19,471	29·6	33,025	50·2
	1923	722.90	28,678	39·7	13,413	18·6	19,687	27·2	35,509	49·1
	1924	726·60	29,282	40·6	14,419	19·8	19,667	27·1	36,179	49·8
	1925	740·70	29,383	39·7	16,016	21·6	17,716	23·9	38,553	52·0
	1926	**726·90**	**28,176**	**38·76**	**14,929**	**20·54**	**23,468**	**32·29**	**41,883**	**57·62**
E ..	1922	555·00	26,014	46·9	9,352	16·9	18,894	34·0	30,252	54·5
	1923	554·00	21,571	38·9	8,809	15·9	13,432	24·2	24,731	44·6
	1924	548·00	20,875	38·1	9,080	16·6	13,701	25·0	24,667	45·0
	1925	556·00	19,981	35·9	9,839	17·7	11,964	21·5	25,295	45·5
	1926	**564·00**	**19,276**	**34·18**	**9,335**	**16·55**	**15,890**	**28·17**	**26,348**	**46·72**
F ..	1922	286·00	11,181	39·1	4,412	15·4	6,479	22·7	14,107	49.3
	1923	288·00	11,037	38·3	4,444	15·4	6,477	22·5	14,319	49·7
	1924	294·00	10,997	37·4	5,198	17·7	6,845	23·3	14,660	49·9
	1925†	288·00	13,011	45·2	6,286	21·8	6,403	22·2	17,876	62·1
	1926	**288·00**	**10,049**	**34·89**	**5,705**	**19·81**	**7,026**	**24·37**	**15,755**	**54·70**
Total ..	1922	2,976·23	£ 106,772	£ 35·5	£ 47,295	£ 15·9	£ 79,948	£ 28·1	£ 138,427	£ 48·9
	1923	3,080·26	99,356	32·3	48,303	15·7	72,131	23·4	136,937	44·5
	1924	3,123·86	101,277	32·4	52,464	16·8	72,599	23·2	142,475	45·6
	1925	3,196·70	104,694	32·8	55,940	17·5	69,163	21·6	152,331	47·7
	1926	**3,225·90**	**99,553**	**30·86**	**54,570**	**16·92**	**82,454**	**25·56**	**158,763**	**49·22**

* Year ended 15th May. † Period of 14 months.

NOTE :—Other Tables relating to the above Hospitals are Nos. 48, 54, 59 and 63.

TABLE 66.

EXPENDITURE ON FUEL AND LIGHT.

Hospitals.	Year.	No. of Hospitals giving details.	No. of available beds.	Expenditure on Coal, Coke, Gas and Electricity.	Expenditure per *available* bed.
Group A	1922	15	3,880	£ 53,542	£ 13·80
	1923	17	4,102	54,707	13·34
	1924	18	5,131	67,200	13·10
	1925	18	5,242	59,013	11·07
	1926	**18**	**5,434**	**81,284**	**14·96**
Group B	1922	18	1,032	12,543	12·15
	1923	19	1,113	13,595	12·21
	1924	21	1,134	13,966	12·32
	1925	24	1,281	14,309	11·17
	1926	**23**	**1,294**	**17,195**	**13·29**
Group C	1922	30	476	5,513	11·58
	1923	37	621	6,886	11·09
	1924	43	721	7,196	9·98
	1925	41	682	5,947	8·72
	1926	**45**	**788**	**7,438**	**9·44**
Total	1922	63	5,388	£ 71,598	£ 13·29
	1923	73	5,836	75,188	12·88
	1924	82	6,986	88,362	12·65
	1925	83	7,205	79,269	11·00
	1926	**86**	**7,516**	**105,917**	**14·09**

SECTION 10.

TOTAL RECEIPTS AND TOTAL EXPENDITURE OF THE VOLUNTARY HOSPITALS IN SCOTLAND.

The financial position of the Scottish Voluntary hospitals for the year 1926 may be summarised as follows :—

Ordinary Income	£ 849,933	Ordinary Expenditure	£ 936,680
Extraordinary Income ...	259,188	Extraordinary Expenditure ...	713
Receipts for Capital purposes	232,976	Capital Expenditure	316,868
		Surplus for the year	87,836
	£ 1,342,097		£ 1,342,097

TABLE 67.

TOTAL RECEIPTS AND TOTAL EXPENDITURE.

Hospitals.	Year.	No. of Hospitals.	Total Receipts.	Total. Expenditure.	Surplus.	Deficit
Group A	1922	18	£ 942,144	£ 677,291	£ 264,853	—
	1923	19	951,586	720,890	230,696	—
	1924	19	1,243,213	762,601	480,612	—
	1925	19	1,094,787	883,129	211,658	—
	1926	**19**	**991,589**	**923,514**	**68,075**	—
Group B	1922	20	197,191	126,347	70,844	—
	1923	20	220,029	132,176	87,853	—
	1924	21	342,496	167,413	175,083	—
	1925	26	263.017	195,609	67,408	—
	1926	**26**	**236,674**	**236,830**	—	**£156**
Group C	1922	41	80,735	65,205	15,530	—
	1923	47	132,672	74,327	58,345	—
	1924	53	128,214	87,767	40,447	—
	1925	50	152,817	123,737	29,080	—
	1926	**54**	**113,834**	**93,917**	**19,917**	—
Total ..	1922	79	£ 1,220,070	£ 868,843	£ 351,227	—
	1923	86	1,304,287	927,393	376,894	—
	1924	93	1,713,923	1,017,781	696,142	—
	1925	95	1,510,621	1,202,475	308,146	—
	1926	**99**	**1,342,097**	**1,254,261**	**87,836**	—

TABLE 68.

HOSPITALS HAVING AN **EXCESS OF TOTAL RECEIPTS** OVER TOTAL EXPENDITURE.

Hospitals.	Year.	No. of Hospitals.	Total Receipts.	Total Expenditure.	Surplus.
Group A	1922	13 (72%)	£ 855,479	£ 581.049	£ 274,430
	1923	18 (95%)	938,274	700,142	238,132
	1924	15 (79%)	1,156,358	666,829	489,529
	1925	12 (63%)	839,319	605,949	233,370
	1926	**9 (47%)**	**771,132**	**660,007**	**111,125**
Group B	1922	18 (90%)	185,903	114,539	71,364
	1923	18 (90%)	212,436	123,775	88,661
	1924	16 (76%)	307,989	120,693	187,296
	1925	18 (69%)	186,440	103,116	83,324
	1926	**17 (65%)**	**144,281**	**101,352**	**42,929**
Group C	1922	32 (78%)	66,545	45,850	20,695
	1923	40 (85%)	122,839	62,372	60,467
	1924	40 (75%)	107,943	64,228	43,715
	1925	35 (70%)	119,149	64,812	54,337
	1926	**37 (69%)**	**83,267**	**54,036**	**29,231**
Total	1922	63 (80%)	£ 1,107,927	£ 741,438	£ 366,489
	1923	76 (88%)	1,273,549	886,289	387,260
	1924	71 (76%)	1,572,290	851,750	720,540
	1925	65 (68%)	1,144,908	773,877	371,031
	1926	**63 (64%)**	**998,680**	**815,395**	**183,285**

TABLE 69.

HOSPITALS HAVING AN **EXCESS OF TOTAL EXPENDITURE** OVER TOTAL RECEIPTS.

Hospitals.	Year.	No. of Hospitals.	Total Receipts.	Total Expenditure.	Deficit.
Group A	1922	5 (28%)	£ 86,665	£ 96,242	£ 9,577
	1923	1 (5%)	13,312	20,748	7,436
	1924	4 (21%)	86,855	95,772	8,917
	1925	7 (37%)	255,468	277,180	21,712
	1926	**10 (53%)**	**220,457**	**263,507**	**43,050**
Group B	1922	2 (10%)	11,288	11,808	520
	1923	2 (10%)	7,593	8,401	808
	1924	5 (24%)	34,507	46,720	12,213
	1925	8 (31%)	76,577	92,493	15,916
	1926	**9 (35%)**	**92,393**	**135,478**	**43,085**
Group C	1922	9 (22%)	14,190	19,355	5,165
	1923	7 (15%)	9,833	11,955	2,122
	1924	13 (25%)	20,271	23,539	3,268
	1925	15 (30%)	33,668	58,925	25,257
	1926	**17 (31%)**	**30,567**	**39,881**	**9,314**
Total	1922	16 (20%)	£ 112,143	£ 127,405	£ 15,262
	1923	10 (12%)	30,738	41,104	10,366
	1924	22 (24%)	141,633	166,031	24,398
	1925	30 (32%)	365,713	428,598	62,885
	1926	**36 (36%)**	**343,417**	**438,866**	**95,449**

TABLE 70.

TOTAL RECEIPTS AND TOTAL EXPENDITURE OF GENERAL AND SPECIAL HOSPITALS SHOWN SEPARATELY.

Hospitals.	No. of Hospitals.	Available Beds.	Total. Receipts.	Total Expenditure.	Surplus.	Deficit.
General Hospitals—						
Group A ..	15	4,979	£ 868,356	£ 776,133	£ 92,223	—
Group B ..	15	794	100,763	89,436	11,327	—
Group C ..	46	768	95,953	74,318	21,635	—
Total	**76**	**6,541**	**£ 1,065,072**	**£ 939,887**	**£ 125,185**	—
Special Hospitals—						
Group A ..	4	715	£ 123,233	£ 147,381	—	£ 24,148
Group B ..	11	634	135,911	147,394	—	11,483
Group C ..	8	148	17,881	19,599	—	1,718
Total	**23**	1,491	**£ 277,025**	**£ 314,374**	—	**£ 37,349**

TABLE 71.

LEGACIES RECEIVED.

Hospitals.	Year.	No. of Hospitals.	No. of available beds.	Free Legacies.	Ear-marked Legacies.	Total. Legacies.	Per *available* bed.*		
							Free.	Ear-marked.	Total.
Group A	1924	19	5,495	£ 385,828	£ 87,883	£ 473,711	£ 70	£ 16	£ 86
	1925	19	5,532	184,307	41,194	225,501	33	8	41
	1926	**19**	**5,694**	**212,740**	**31,638**	**244,378**	**37**	**6**	**43**
Group B	1924	21	1,244	94,438	9,838	104,276	76	9	85
	1925	26	1,389	27,674	1,114	28,788	20	1	21
	1926	**26**	**1,428**	**34,669**	**3,700**	**38,369**	**24**	**3**	**27**
Group C	1924	53	844	15,303	5,800	21,103	18	7	25
	1925	50	811	15,556	9,429	24,985	19	12	31
	1926	**54**	**916**	**9,341**	**1,200**	**10,541**	**10**	**1**	**11**
Total	1924	93	7,583	£ 495,569	£ 103,521	£ 599,090	£ 65	£ 14	£ 79
	1925	95	7,732	227,537	51,737	279,274	29	7	36
	1925	**99**	**8,038**	**256,750**	**36,538**	**293,288**	**32**	**5**	**37**

* Calculated to the nearest £.

THE FUNCTION OF THE VOLUNTARY HOSPITAL IN RELATION TO PUBLIC HEALTH SERVICES.

A Paper read before the Annual Conference of the British Hospitals Association, Norwich, 24th June, 1927.

BY

The Hon. SIR ARTHUR STANLEY, G.B.E., C.B., M.V.O.,

President of the Association.

Every thoughtful man and woman connected with the work of the Voluntary Hospital has, for the past few years, been conscious of a growing feeling that a change has been taking place in the hospital world, and that, in some respect or other, the Voluntary Hospitals would, sooner or later, be obliged to reconsider their position in regard to the general social welfare of the population. There is, I think, little room for difference of opinion as to the changed character of the social medium in which the Voluntary Hospitals now work. They were, in the past, founded to give, not necessarily *expert* medical treatment, but *some* treatment, to the sick poor. How far we have travelled from that standpoint can best be realised when it is remembered that the treatment of minor ailments is now undertaken by panel doctors under the National Health Insurance Acts : and what amounts to a new class of patient has been introduced by many of the contributory schemes now in existence. This difference, so palpable as to be almost commonplace, is yet frequently overlooked in any discussion of general principles, and the Voluntary Hospitals are often still credited with characteristics which they have long outgrown. If, however, they have outgrown some part of their former scope, they have taken on additional work in other directions. They now provide medical relief and treatment at the highest standard of efficiency and this standard of efficiency progresses with the development of medical science : they train doctors, nurses and social workers, and they advance and facilitate scientific research in the treatment and prevention of disease.

It may be stated, without hesitation, that the medical profession have settled largely amongst themselves the question of the proper function of the Voluntary Hospitals. By their very generosity in giving of their best they have altered the character of these institutions until, from being merely dispensers of charity, they have become the main centres of training and research. Throughout their progress to this end they have, as we all know, maintained a state of isolation—they have progressed on their way in absolute independence, and although they have all eventually arrived on the same track, they have not set their helm by any fixed star, nor steered their course by any official chart. This was not of so much importance while the State, in respect of its public health responsibilities, was content to be driven by circumstances rather than be guided by principle. The Voluntary Hospitals have been masters of the situation, both individually and collectively, and between themselves and the State and Public Authorities little or no thought of organised co-operation existed. It is obvious, however, that when one of the factors in this situation underwent a change, the other could not fail to be affected. The factor which has changed is, of course, the State's conception of its duty in regard to public health services. At first by slow steps, and latterly by great strides, the State has overtaken this question, and instead of being driven by circumstances it has assumed a policy of initiative and aggression.

The great progress made by the public authorities, acting under the authority of the State, during recent years, has brought about a very big change, and the time has arrived when the effects of this change upon the general situation must be considered. The Public Health Acts, interpreted in a broad-minded and sagacious manner, have set working a mighty health machine. It is quite feasible to argue that this machine will not be allowed full play, and that numerous considerations may limit its activities for some time. The fact remains, however, that this new factor has arisen and that the Voluntary Hospitals, if they adopt an attitude of aloofness, might in the end find the ground cut from under

their feet, because public enterprise and State resources had rendered their work supererogatory. Fortunately, there is little occasion for alarm in this connection, as the Voluntary Hospitals have always signified their willingness to co-operate in a co-ordinated scheme of hospital and health service.

The present position has been brought about through the absence of a considered policy in the development of the health service of the country. If we consider the process of development of hospitals and similar institutions, we shall find that they have not developed along the lines of a clearly defined and consciously directed policy. As the population has grown, and as increasing demands have been made for the treatment of certain diseases, more or less of a national or semi-national character, hospitals have been erected, some by the State, some by Public Authorities, and some by voluntary effort. If to-day we take any given area, we shall find a larger or smaller collection of residential and other institutions for the treatment of the sick. A large county area will contain general hospitals, poor law infirmaries, isolation hospitals, hospitals and sanatoria for tuberculosis, hospitals and asylums for mental cases, lying-in institutions, homes for women and children, and hospitals for special diseases—skin, ear, nose and throat, cancer, ophthalmic, orthopaedic, fever, etc. In addition, we shall find a maternity and child welfare service, an ante-natal service, a school medical service, and clinics for venereal diseases, tuberculosis, etc. If we map out this imaginary area we shall discover that the hospitals and institutions are dotted about with but little regard to the present needs of the population. Ancient and mediaeval reasons account for distribution, and a score of accidental factors, other than the essential factor, have played their part. There is entire absence here, redundance there ; sound representative government here, but arbitrary and capricious control there ; here an open door and a crowded out-patient department, there a " letter " system and no crowding ; further, there are considerable differences in the conditions of admission, of contributions from patients, of nursing, of treatment, and so forth. There is, in fact, no general hospital or public health service ; there are hospitals and services, it is true, but they are controlled by a number of miscellaneous bodies and authorities, and there is, in consequence, considerable overlapping, waste of accommodation, and a waste of public funds and contributions. Each Voluntary Hospital is managed by a Board of Management, and each is a law unto itself ; the London fever hospitals are managed by a hybrid body on which the Ministry of Health and the boards of guardians are both represented ; other fever hospitals and sanatoria by the county and local health authorities ; the public asylums by the county and county borough councils, and the poor law infirmaries by the boards of guardians. In addition there are the panel doctors under the National Health Insurance scheme. There is no general system of co-operation or co-ordination, nor is there any definite division of work or of responsibilities between these institutions and services. As a result, we have at the present time a large and heterogeneous accumulation of health and hospital services, more or less suited (but not necessarily adequate, particularly as regards certain categories of cases) to the needs of the population. Moreover, they are inelastic in their organisation, and not fully adjusted to meet the economic status of the several classes requiring their services.

It will be appreciated at once that all the essential elements which are constituent parts of a complete public medical service on behalf of the sick are in greater or lesser degree in existence ; they do not call for creation, they call rather for readjustment, correlation and development. This is obviously the object for which we all should strive, and in the attainment of this object it is equally obvious that the Voluntary Hospitals can and must play a very important part. What this part shall be has yet to be determined. It is difficult, owing to the lack of co-operation between the Voluntary Hospitals themselves, to determine fully just what relationships exist at present between the various authorities, and further, just what the relationships should be, both in the interests of the individual hospital, and in the interests of the common welfare.

We have, therefore, to ask ourselves the question : What are the desirable relationships which should exist between the Voluntary Hospitals and the State and public authorities ? As a guide in the consideration of answers to this question I give below an extract from a letter from the Secretary to the Minister of Health, dated February 15th, 1927 : —

" The following are among the questions which it is suggested that the Voluntary Hospitals should proceed to examine in conjunction with the local authorities, including boards of guardians :—

1. Having regard to the nature of the hospital accommodation available in the area, both in Voluntary and Public Hospitals, are there any categories of cases which should, so far as practicable, be allocated to one type of hospital or the other ?

2. Is it possible, after taking stock of local needs, to agree on any lines of demarcation between the province of the Voluntary and Public hospitals in the area ?

3. Assuming that some understanding is reached as to the line of demarcation between the Voluntary and Public hospitals in a given area, to what extent would this modify schemes of enlargement in hand or in contemplation ?

4. If there is a shortage of Voluntary Hospital beds, in what respect is the shortage most serious, *e.g.*, is it a shortage of general surgical or medical beds, gynaecological or maternity beds, or orthopaedic ? Is there vacant accommodation in Public hospitals suitable, or capable of being adapted, for the type of case for which accommodation is specially needed ?

5. Could not some " Clearing House " arrangement be established by agreement between the Voluntary Hospitals and the Local Authorities (including the guardians), which would ensure a better distribution of patients and the more rapid admission of cases requiring institutional treatment ?

6. To what extent and under what conditions could the medical staffs of the Voluntary Hospitals undertake responsibility for cases, or for a definite number of beds, in Public hospitals, so that the patient may be secured of the special type of experience required, whether medical or surgical, without regard to whether the bed he occupies is under Voluntary or Public management ? "

These are questions requiring deep thought, and I leave them to the earnest consideration of you all. They will occupy considerable time, and it may well be the case that variations in local circumstances may indicate the need for a wide measure of elasticity, nor will it be practicable to seek a solution on uniform lines in all areas. At the same time, while complete uniformity of practice may not be attainable, and may not be even desirable in all cases, it is necessary to consider to what extent it may be wise to formulate, for the guidance of the Voluntary Hospitals generally, any general principles by which they should be guided in seeking a solution of these questions in their several areas.

Having arrived at solutions to these questions, you have then to consider by whom such relationships are to be established. The initiative is at present with the State and the Municipalities. This is not altogether a desirable situation, but it is no good our criticising existing conditions without taking the steps necessary to bring about a change, and this change can only be brought about by a close co-operation between the Voluntary Hospitals themselves—we must give up our isolated existence, and we must get together in a real attempt to arrive at a uniform policy to guide us in our negotiations with other authorities. That a uniform policy for the Voluntary Hospitals is necessary will be obvious to you all. The Voluntary Hospitals have for long opposed State aid on the ground that it would be the forerunner of State control, or even of State administration and nationalisation. There are signs, however, that gradually the State is drawing the Voluntary Hospitals into a public medical service, and the hospital, whispering " I will ne'er consent," consents to receive payment for carrying on certain work for the State. They are, in fact, taking a very active and a very proper part in a public medical service. They receive payment for work in connection with venereal disease, maternity and child welfare, ante-natal clinics, tuberculosis, etc.—all responsibilities of the State, but responsibilities which the State would have been unable to perform without the assistance of the Voluntary Hospitals. Whether these payments come from the State or from the Municipal authorities, the principle is the same, and, in this way, little by little, the Voluntary Hospitals are becoming part of a State scheme without the more spectacular Treasury grant.

In a consideration of the questions raised it is of the greatest importance that the Voluntary Hospitals should take a very broad view of the position. That they must form an indispensable part of any general scheme has already been emphasised, but they ought not, and should not, embark upon any scheme with a limited outlook—treatment must not be the sole object of their work in a general

scheme. It is desirable that they should consider all associated problems and be prepared to offer sound opinions based upon the experience which they have acquired. The limitation of interest to treatment will not result in that complete advantage to the public which their contributions require. A hospital, in its broader aspect, has four main functions—healing the sick (medical function); training of those who care for the sick (teaching function); prevention of disease (research function); constructive health building (social function). Only in so far as a hospital accepts, in a greater or lesser degree, the obligations of these four responsibilities does it function in the true sense of the word as a Community Hospital; with the fulfilment of these functions it becomes naturally the health centre of the area it serves. I should like to see the Voluntary Hospitals develop more and more on these lines and become the real centres of medical life in the area in which they are situated. This should be their true function in relation to a public health service, and all clinics and treatment centres under the public services should be associated with Voluntary Hospitals.

The day is passed when a sharp line of demarcation may be drawn between the functions of curative and preventive medicine. Perhaps it is doubtful whether a clean-cut distinction was ever justified. In any event, the relationship is daily becoming more and more intimate as progress in prevention develops on lines which are very closely related to social work. The Voluntary Hospitals now exist for the prevention as well as the cure of disease, and it is, therefore, the duty of all connected with these hospitals to emphasise the importance of the work of their institutions, and also, as far as it lies in their power, to mould the future public medical service while it is yet plastic. In this connection the advantages of publicity should not be ignored. An extreme observance of hospital ethics should not be allowed to prevent the proper use of publicity, and a proper and dignified presentation of the views and ideals of the Voluntary Hospitals. Publicity does not necessarily mean advertising; advertising is a means to create sales for a tangible product or service, while publicity is a means by which public opinion is moulded to the acceptance of an ideal or service. An educational publicity campaign on behalf of the Voluntary Hospitals as a whole would, I believe, be more beneficial than the thousand and one appeals for funds which are constantly before the public.

It is common ground that the medical services of this country need better co-ordination, and it is also common ground that in the process of that co-ordination as few radical changes as possible should be made. We are not in Utopia, and we are not starting with a clean sheet. The best we can do for the present is to take the materials at our disposal and weave them into a sound and composite whole, and the more nearly we retain the broad outlines of the existing schemes the more likely are we to produce a plan which will be quickly practicable.

Any scheme for the co-ordination of hospital and medical services should, therefore, aim at establishing the Voluntary Hospitals in the position which they have as yet only partially attained, namely, that of consultative centres. I consider this to be an important function of the Voluntary Hospitals. It can hardly be doubted that in such a scheme the poor law infirmaries will develop as municipal hospitals; they will not merely receive a definite status, but they will be given enhanced and important functions. The old prejudice against the infirmaries is fast dying out, and when complete dissociation is achieved (both in law and in popular imagination) between the workhouse and the infirmary, these institutions will come into their own. With a co-ordinated scheme this is as it should be; the patient should be led to feel that his medical condition is the deciding factor, and that in all respects he will be as well treated and looked after in an Infirmary as in a Voluntary Hospital. When once this belief has been instilled into the minds of the people, and the old prejudices eradicated, the infirmaries will develop into valuable adjuncts to the Voluntary Hospitals, taking not merely chronics and incurables, but all simple and medical and surgical cases which the domestic circumstances of the patient might render unsuitable for treatment at home. It will ensue from these developments that the clinical material in the infirmaries will be available for teaching purposes, and it would be both reasonable and practicable that students should start their training with the chronic and more simple cases, proceeding later to the study of special and the more complicated cases. The Voluntary Hospitals would continue to be the teaching centres for the profession, and the overlapping between voluntary agencies and the public authorities as regards duties and responsibilities would be prevented to a very great extent. With the proper relationships established, the Voluntary Hospitals, relieved of all their trivial cases,

would be able to devote their energies, accommodation and funds to special work—work for which it is generally admitted they are admirably suited.

The Voluntary Hospitals are fast arriving, if they have not already arrived, at the parting of the ways, and they cannot hope to take their proper high place in the prevention of disease unless they accept the undoubted advantages of a co-ordinated scheme of public medical service. By their treatment, instruction and guidance of the patient, and by their research and consultative services, the Voluntary Hospitals will be able to fulfil most important functions in the prevention of disease, and to that extent the promotion of public health. They have a brilliant record behind them—record of service to the community not equalled by any other form of institution ; by recognising fully the effects of the great changes that have taken, and are still taking place, and by adopting a broad-minded policy in their relations with the State and Municipalities they have exceptional opportunities of surpassing this record in the future.

THE RELATIONSHIP BETWEEN THE VOLUNTARY HOSPITAL AND THE HOSPITAL PROVIDED BY PUBLIC AUTHORITIES.

Early in 1927 we asked several of the Administrative Officers of large Provincial Voluntary Hospitals to write their personal views on the relationship of the Voluntary Hospital to the Hospital provided by the Public Authority, and suggested for their consideration the following queries :—

1. Is it possible and advisable to attempt to define the spheres of activity of the Voluntary and Local Authority Hospitals, and, if so, what are the definitions ?
2. Can the Voluntary Hospitals provide the Funds to meet the needs within their defined sphere of activity ?
3. It is stated that the development of the Local Authority Hospital in an area will gradually reduce the support of the Voluntary Hospital. Is this so ? Do not Public and Voluntary Hospitals work successfully side by side in the Dominions and U.S.A. ?
4. Can a scheme of whole-hearted co-operation be devised which will preserve the character of the Voluntary Hospital, maintain its support, and graft on to State Institutions all those desirable qualities that have made the British Voluntary Hospitals what they are ?

We have great pleasure in publishing the views which have been so kindly written for this Report by Administrators from widely separated areas of the country.

1.

The Great Voluntary Hospitals have reached their present proud position through being free and (except for debt) unfettered, and the majority of English people, I feel sure, desire that they should remain the great curative and preventive Institutions which they now are and have been throughout the past century. Whatever alteration or changes take place in the future, the Voluntary Hospitals should use all means in their power to retain their freedom and independence. Their problem is finance, and for this reason the financial aid the Hospitals need should come from the State as grants in aid according to work done and its resultant cost thereof. A Hospital, without sacrificing one jot of its voluntary principle, could accept such grants ; these would be, in a measure, prizes, the most efficient Hospitals obtaining the largest grants or prizes. For this help from the State, returns would doubtless be called for and willingly supplied ; representation might be claimed and what objection could there be to the Minister of Health for the time being becoming a member of each Hospital Committee *ex-officio*. This would secure the right of the Ministry to look into figures of any particular Hospital.

The Voluntary Hospitals are at the parting of the ways, the Ministry of Health having already entered the field, and the great problem of providing beds and using beds at present Poor Law, but which may shortly be Municipal, is a position with which the Voluntary Hospitals must deal. Every Hospital Board should be in a position to answer the six questions set out in a letter from the Ministry of Health to the British Hospitals' Association dated 15th February, 1927, and at the same time they should carry the position one stage further in advocating annual grants in aid according to work done. The Voluntary Hospitals should assure the Ministry of Health that they and the Medical Staffs connected with their Hospitals were prepared to co-operate to the fullest extent with the Municipal Authorities

immediately the present Poor Law beds were handed over. There should be no competition between the two Hospitals. By co-operation, cases could be transferred freely, although it might not be possible to put cases into categories for allocation to one particular Hospital or the other. It would be an advantage to a Municipal Hospital Committee to have representatives who have been connected with Voluntary Hospital Boards of Management to co-operate with them, and what real objection could there be to some representation by the Municipality on the Voluntary Hospital Boards.

If the principle of State aid for the Voluntary Hospitals be firmly established, the future of the latter will be lasting. The days when the Voluntary Hospitals were supposed to exist only for the indigent sick and necessitous have gone. All Hospitals are now treating in their wards patients who are termed in England "Black-coated Workers," and in America, "The White Collar Brigade." This class of person is in a large measure the problem of to-day, not only do they become a question for the Voluntary Hospitals, they are also a question for the Municipality, and they are a most difficult problem for the Honorary Medical Staffs of the Hospitals. Medical Staffs as a whole desire to see our great Institutions voluntary as heretofore; in most cases they have grown up with their own particular Hospital, they were trained there and they have grown to love their Institution. A member of the Honorary Medical Staff of the Hospital with which I am proud to be connected, left, a few years ago, over £30,000, practically his whole fortune, for a Home of Rest for our Nursing Staff. Could this love and affection, and all that it stands for, remain if the Voluntary Hospitals were done away with? The Medical Staffs are bound up with the whole of our problems, and with whatever co-operation there may be between the Voluntary Hospitals and the Municipality.

One of the first questions with which a Joint Committee would be confronted would be that of paying patients. Some Hospitals are already treating paying patients in their wards, but the great majority of Hospitals have not yet dealt with this matter. It is unlikely that any hard and fast line could be drawn, applicable to all Hospitals. In some areas Voluntary Hospitals might decide to deal with paying patients, while in others, they could by arrangement be treated at the Municipal Hospital; in any case paying beds should be self-supporting.

The relationship of the Voluntary Hospital and the Municipality should be at its closest when dealing with " After Care " or Social Service. The Voluntary Hospitals through lack of income have, in the past been unable to do justice to this rightful part of a Hospital's work. " After Care " or Social Service could be run conjointly and could be administered by the Municipality. Social Service Workers could attend patients on their discharge, and could follow up cases from the Out-Patient departments of the Hospitals.

Difficulties would be many but they would all be overcome, and we should advance on the wheel of progress, the result of our efforts being a happier and a healthier nation.

It would doubtless be said that with State aid, and fullest co-operation between the Voluntary Hospitals and the Municipality, our Hospitals were no longer Voluntary, but the writer feels that we should emerge stronger and more powerful than we have been since the Great War, which threw Hospitals, like every other part of the nation's machinery, into the melting pot.

The views given are personal, and must not be taken to represent the views of the large Hospital I have the honour to serve.

J. W. BARNES,
Secretary,
The Royal Infirmary, Sheffield.

2.

The Local Authorities are certainly developing their Hospitals independently on their own lines, and not in co-operation with the Voluntary Hospitals. The same may also be said with regard to the latter.

May I suggest that it is highly desirable that a complete co-ordinated scheme of public health services should be arranged, and that it should be first considered by the Local Voluntary Hospitals

Committees at the instigation of the Minister of Health. I believe that this can be attained without prejudice to the Voluntary System, provided that some mutual arrangement can be come to with the medical profession. Failing this, it would be futile to attempt to formulate any kind of co-ordinated scheme. That such a scheme would be an advantage is obvious for many reasons ; it would ensure a better use of all available beds in the district ; it would prevent to a large extent our specialised Voluntary Hospitals being used for cases of minor ailments ; it would open up a wider field for the treatment of insured persons and their dependents ; it would prevent overlapping and delay in treatment, and materially assist the tax-payer and supporters of our great charities.

It is essential that the spheres of activity of all hospitals or centres for the treatment of the sick should be defined, as some line of demarcation must be established before co-operation or any working arrangement can be made possible.

The large Voluntary Hospitals should, in the main, be reserved for cases requiring special diagnostic facilities, or a high degree of technical skill ; for the treatment of major or difficult cases referred by the General Practitioner ; for the treatment of all accidents or emergencies ; for purposes of consultation or special examination ; for cases of acute or obscure illnesses, teaching and research. The overcrowding in the Out-patient Departments of the Voluntary Hospitals would be greatly relieved if cases of minor ailments could be treated at some more convenient centres. In this Institution last year over 40,000 casuals were seen by the Resident Medical Officer, and of these it was only necessary to refer 11,000 to special departments for further treatment. This means that 29,000 cases of a trifling nature, which could easily have been dealt with elsewhere, attended. The Auxiliary Hospitals, including Municipal and Poor Law, should deal with chronic cases or cases that require a prolonged stay ; diseases which are a menace to the community, *e.g.*, those included under the Infectious Diseases Act ; cases of minor ailments and convalescence, and those for which the primary need is skilled nursing, or which cannot be finally dealt with in the surgery of the Panel Practitioner.

I am of opinion the Voluntary System can be maintained, not by voluntary contributions in the true sense, that is, contributions given freely without involving any obligation of service on the part of the hospital, but by an efficient contributory system properly organised, where service rendered, or to be rendered, is implied. The development of the Local Authority Hospitals is bound eventually to affect the support of the Voluntary Hospitals, as during the last few years huge sums of money have been spent in bringing these Institutions up to date. In fact, some of them are to-day much better equipped than the average Voluntary Hospital, and it only remains for them to appoint an Honorary Staff and to grant easier facilities for admission. When such time arrives it will undoubtedly be detrimental in many ways to the interest of the Voluntary Hospitals.

I believe a contributory scheme as outlined in the policy of the British Medical Association is practical and sound and would preserve the character of the Voluntary Hospitals, maintaining, as at present, the independent and voluntary management. It is vitally neecessary that the Voluntary Hospitals take their proper place in the treatment of disease and accept the undoubted advantages of some kind of co-ordinated scheme of public health services.

S. DUNSTAN,
House Governor and Secretary,
Royal Victoria Infirmary, Newcastle-on-Tyne.

3.

Over a year ago the Mackenzie Hospital Services (Scotland) Committee, appointed "to enquire into and report upon the extent and nature of the inadequacy of the present hospital and auxiliary services in Scotland and to make recommendations for the development and maintenance of those services to meet the needs of the community," published their findings. The report pays tribute to the work of the Voluntary Hospitals " which have done such splendid work in the past and, without any interference from the State, have evoked a widespread spirit of service. Any interference with them which would tend to impair their voluntary character would be not only unpopular but also thoroughly bad policy." Attention is drawn to a shortage of fully 3,000 beds for general hospital purposes, and in order to supply

this need it is suggested that the State should contribute £900,000—a fifty per cent. Treasury Grant —leaving the other half to be raised by the Hospitals themselves. "For maintenance, we have recommended an annual contribution from national insurance funds, and we have also suggested other sources from which additional revenue may be obtained. Judging from the evidence we have received, the problem of completing the revenue to meet the additional annual cost can be left to the generosity of the public." It is recommended that Poor Law Hospitals—which were found to be fully occupied, except in Glasgow and Aberdeen—be transferred to public health authorities in order that the sick may be removed from the stigma of the poor law and to avoid a possibility, which exists, *e.g.*, in Glasgow, with its up-to-date parochial hospitals, of a third party, viz., the Parish Council, advancing into a position, as regards facilities for patients, parallel to that of voluntary bodies, thereby adding to the complexity of the problem and rendering the end in view, viz., "a complete and efficient hospital service," all the more difficult to secure. A key to the situation is found in co-operation between Voluntary and Rate-aided Authorities, and it is proposed that a permanent central hospital commission should, *inter alia*, assist in co-ordinating hospital services. "The most obvious advantage of co-operation is that it prevents duplication of service" and "the costly equipment which some modern methods require should not be duplicated unnecessarily." While it is emphasised that, in the interest of the patient, it is of great importance and necessity to link up smaller hospitals with the central teaching hospitals, attention is drawn to the success attending schemes of co-operation already arranged between voluntary and rate-aided bodies. A few of these efforts and other matters of interest will now be noted.

Tuberculosis.—The campaign against Tuberculosis was opened in Edinburgh in 1887, by the Royal Victoria Trustees and continued for nearly 20 years on a purely voluntary basis. Until within very recent years, local authorities—although possessing powers—have focussed attention on pulmonary tuberculosis, leaving those suffering from non-pulmonary disease to be treated in the out-patient departments or wards of general hospitals; as it is, some patients afflicted with tuberculosis of the lungs are now receiving attention in Voluntary Hospitals for longer or shorter periods without any financial aid from the rates. Voluntary agencies also continue the pioneer work which they inaugurated and extend their endeavours, as suitable opportunity arises. "A noteworthy voluntary development has been the opening of Southfield Sanatorium Colony at Liberton, Edinburgh, established by the Royal Hospital Tuberculosis Trust. This Institution, which is under the direction of Sir Robert Philip, will specialise in cases presenting exceptional difficulty, the object being not only to benefit patients requiring prolonged treatment and continuous care, but also to advance the knowledge of the disease and the methods of combating it." (1922). Again, the Directors of Dundee Royal Infirmary acquired in 1910, as an adjunct to their department for diseases of children, the Sidlaw Sanatorium for the treatment of children suffering from medical and surgical tuberculosis, and by utilising half the available wards accommodated 40 patients. This summer the other wards have been opened at a cost of £1,300, the Directors being encouraged to undertake the necessary alterations to provide for an additional 40 children by the manner in which the Town Council received their representations for a contribution up to £3,000 per annum.

Venereal Disease.—"At The Royal Infirmary of Edinburgh, for example, there is admirable and indeed perfect co-operation between the Venereal Diseases Section and practically all other departments of the Institution. So diverse are the manifestations of venereal disease, especially of syphilis, that there is not a single ward or department of any large infirmary but has a proportion of its beds occupied by patients whose maladies are ascribed to one or other of these specific infections. This applies not only to cases such as aneurism, aortic diseases of the heart, gummatous swellings and grave and progressive disorders of the central nervous system, such as are to be found in the ordinary medical wards, but also to cases in surgical, skin, gynæcological, nose, ear, and throat and eye wards. It is therefore of supreme importance, alike to physicians and surgeons in these wards, and to the clinical workers in the venereal diseases section itself, to be in close touch with one another, so that their experience, records, appliances and skill may be mutually available. Such a close working co-operation and inter-relation should be established and maintained in every large Hospital; and it is one argument, and a powerful one, for establishing the venereal diseases clinic, when that course is possible and convenient, in an existing institution." (1924).

Maternity Service.—" During the year an interesting scheme of co-operation between the Glasgow Maternity Hospital and Stobhill Poor Law Hospital was evolved. For some time the demands on the Maternity Hospital had been in excess of the available accommodation. On the other hand, there was at Stobhill Hospital suitable vacant accommodation. With a view to arriving at some method of co-operation that would meet the difficulty, a conference was held in Glasgow at which representatives of the Maternity Hospital Directorate, the Parish Council, and the Central Department were present. Following this conference, details were discussed between the Maternity Hospital Authorities and the Parish Council and a minute of agreement was finally drawn up, under which the Parish Council undertook to provide satisfactory accommodation in Stobhill Hospital for maternity cases, who, through lack of accommodation, could not be admitted to the Maternity Hospital. Such cases are to be sent direct to Stobhill Hospital by the receiving house surgeon at the Maternity Hospital, and they are to be treated as Maternity Hospital cases, and shown as such on a special bed card. The necessary treatment will be afforded by the Stobhill Hospital Medical and Nursing Staff. The Maternity Hospital assumes financial liability for the cost of each case, the amount payable being based on the average daily cost of patients in Stobhill Hospital as ascertained for the previous financial year. This agreement, which is obviously in the public interest, marks an important step in the development of hospital services. While in the past, public health authorities and parish councils have co-operated in the provision of accommodation in poor house hospitals for persons suffering from tuberculosis, venereal disease, etc., where the health authority had not themselves been able to make adequate provision, no attempt has ever been made to achieve co-operation on any substantial scale between the poor law hospital and the voluntary hospital." (1925). Recently it is stated that this arrangement is working well, and continuing to relieve the Maternity Hospital.

Such co-operation in midwifery and other departments of medical practice is possible and desirable only in certain circumstances ; in other large centres, it is not feasible. Nevertheless it may be noted in passing that considerable liason exists between Craiglockhart Poor House Hospital and the University of Edinburgh, in regard to clinical instruction which " cannot fail to benefit not only those who are training to be future healers of the sick, but also the patients themselves, who have the satisfaction of being examined by physicians of the highest standing and of international repute." (1920).

The Aberdeen Joint Hospitals Scheme.—Some years ago, Professor Matthew Hay, appreciating the inadequacy of the Hospitals in Aberdeen and district, advocated the grouping on one site of the Royal Infirmary, Children's and Maternity Hospitals—these being rebuilt and maintained by voluntary effort ; of a tuberculosis sanatorium—provided and maintained by the public health authority ; and of a pathological and bacteriological department—provided by the University : to this was added, at a later date, a hospital for paying patients, built by voluntary effort. While this scheme was generally approved, little headway was made to secure funds for the most ambitious part of the undertaking, viz., the rebuilding of the Royal Infirmary. About a year ago, the local authority announced a new project, which included buildings with extra accommodation for 140 beds and a new venereal disease ward and department ; also the transference from the parish council of all its hospital beds—many being vacant—which would be utilised for all poor law patients, hitherto cared for by the parish council, as well as those suffering from tuberculosis, pneumonia and other diseases. The Board of Health, construing this proposed contract as anticipating the recommendations of the Mackenzie report, approved, prescribing, *inter alia*, " that the Town Council should seek co-operation with the University and Voluntary Hospitals as an active principle in carrying out the scheme." (1926). It would appear, however, that the promulgation of this plan—which it is understood has been delayed—has served to arouse a very notable and lively interest in the voluntary principle. The Lord Provost appeals for £400,000 " to enable the Directors of Aberdeen Royal Infirmary to build and equip an Institution which will not only meet the urgent requirements of our own day, but serve, as we believe, the steadily growing needs of future generations," and to augment the endowment fund to meet the increased cost of maintenance. Within a very short period, and although many sources have not yet been organised, £250,000 has been subscribed. Meanwhile the erection of the new Children's Hospital makes progress, and sufficient funds are in hand to build the Maternity Hospital and " Watson-Fraser " Hospital for paying patients.

Such zeal for the voluntary system is typical. The Royal Infirmary of Edinburgh has been very active of late in providing greater accommodation in the hospital itself, convalescent homes

and other institutes for special treatment, and has acquired adjacent ground on which it is proposed to build a large Maternity Hospital; the new X-ray, electrical and massage pavilion has no equal. In Glasgow, practically all the hospitals, including the three large General Hospitals, are being continuously engaged either in important extensions, or in re-building. At Dundee Royal Infirmary, new departments have been inaugurated and the bed-state of others increased: the new "Marryat" operation theatres are considered the best in the country; and a handsome gift of £60,000 has enabled the Directors of the Royal Infirmary not only to proceed with the erection of the new "Sharp" Maternity Hospital, in conjunction with the Department of Gynæcology, thereby doubling the existing accommodation, but also to provide partial endowment. And this enthusiasm, amounting almost to a renaissance, has not been confined to the "mother" hospitals associated with teaching schools. At Inverness, for example, an enlarged and up-to-date hospital is being built; it will serve a wide northern area. On one occasion, zeal to provide the best for the sick found an outlet in an unusual channel; a unique gift was handed over to Galashiels, viz., a New Hospital, "the best furnished and equipped for its size and kind in the country," to be used by the local authority in the treatment of infectious fevers—a service which the public health department must provide at the cost of the ratepayers. (1924).

In its own wide and comprehensive sphere the Voluntary Hospital is appreciated, and there is a desire for no other. As regards particular departments, *e.g.*, tuberculosis, child welfare, etc., which municipalities may maintain at their own expense, voluntary effort is by no means lacking, and co-operation is sought. As new circumstances arise—and particularly if they are permitted to arise in none too drastic a fashion—the occasion will be met in the same spirit of mutual helpfulness and with a desire to further the best interests of the patient, of public health and of economy. Again each voluntary hospital, particularly a "Mother" Hospital, has its own individual character, and is a centre of pride to its area—considerations which are worthy of great respect from those who might have the temerity to legislate hastily in respect of hospital services. An extract from a leader in a recent issue of the "Scotsman," following a meeting of the British Medical Association in Edinburgh, may interest readers in England, where a possible relationship of municipalities to voluntary hospitals is engaging attention. "Mr. Neville Chamberlain has hinted more than once that the time is at hand when the problem of hospital organisation must be considered with a view to evolving a co-ordinated scheme covering the various localities and the country as a whole. That there should be co-operation between voluntary hospitals and municipal hospitals in order to prevent overlapping and waste of effort will be generally conceded. But there is ground for apprehension as to what form co-operation may take on the part of the latter, with the full machinery of the State, including rating powers, at their back. Speaking for Scotland, Sir Norman Walker, who was a member of the Mackenzie Commission on Hospitals, said yesterday he had been surprised to find how much co-operation was going on under present conditions in an informal way. It may well be asked whether it would not be better to trust to such voluntary co-operation than to attempt to lay down any cast-iron system. Doubtless the Minister of Health has no desire to destroy the voluntary system, but that is what his proposals might result in if the Municipal or State authorities were allowed to have the controlling voice. If there is to be a definite scheme of co-operation then, as was suggested yesterday, the voluntary hospital with the teaching school should be the nucleus of the local hospital system, the "Mother" Hospital of the group. Exception may be taken, however, to the further suggestion that proper co-operation could be ensured only if the voluntary and municipal hospitals were to a great extent under the same management. No doubt if the municipalities contributed to the upkeep of the voluntary hospitals out of the rates they could found a case for a share in the management. That, however, might be but the thin end of the wedge of official control. It behoves those, therefore, who are firmly convinced of the desirability of preserving the voluntary principle, in the interests of the patients particularly, to see to it that these institutions are adequately supported so as to avoid the unwelcome necessity of applying for aid out of the rates."

I thank those who have supplied information. Dates within brackets refer to years of Reports of the Scottish Board of Health.

H. J. C. GIBSON, M.D.,
Medical Superintendent,
Dundee Royal Infirmary.

My opinion, which does not represent that of any locality or of the Committee of any Hospital, is that relationship between the two is constitutionally impossible. Constitutionally because the spirit of voluntaryism gave the Voluntary Hospital its birth and sustains its body, and will ever distinguish it from the alternative form of service.

Faith.—The origin of every Voluntary Hospital, from the oldest to the newest, from the smallest to the largest, is the same : Charity—or to give the better translation of the apostolic term—Love. Love—finding practical expression. The origin of every Hospital provided by the Local Authority is the same : Necessity.

While there were Medical Schools 4,000 B.C., the first Hospital in the modern sense was founded in Rome by the Christian Lady Fabiola. The Voluntary Hospital was one of the first practical expressions of the new value given to human life by Christianity.

The public can grasp the idea that a lunatic at large is apt to become a public nuisance if not a danger, and raise no objection to his confinement in an Asylum. Neither does the public object toa person stricken with fever being removed from its midst.

Public opinion has decreed that these things shall be done : there is no option.

But the person with cancer is a free agent. The complement of a free agent is a Voluntary Hospital.

There are those who would co-ordinate the Voluntary and the Provided Hospital or make them co-operate, or both. But a person must enter a Hospital provided by the Local Authority of his own free will in the same way as he enters a Voluntary Hospital. Have those who would co-operate ever experienced the difficulty of persuading a chronic patient in a Voluntary Hospital that he would be just as comfortable, well treated, and nursed in a Hospital provided by the Local Authority ? Co-operation would not diminish the waiting list.

There are those who from ulterior motives pretend that charity has a taint. On the contrary there is that whole number—4,750 in one district alone on 31st December, 1925—who preferred to await indefinitely admission to a Voluntary Hospital rather than be known to have sought admission to the Hospital provided by the Local Authority. I have heard it said, " If I must go, I must, but for God's sake, don't let me be *buried* by ' The Parish.' "

The dread of a Voluntary Hospital is real to some of those without previous experience. The dread to men of being nursed by women. The dread of an anaesthetic. The dread of an operation. The dread of X-rays. The dread of the publicity of a ward. The dread of being experimented upon.

But this dread is not so deep as the dread of a Parish Institution. For without doubt the dread of a Hospital provided by the Local Authority also exists. The dread and the social disgrace of " The Parish " dies hard in those who would improve their social status.

The warm relationship of the public to the Voluntary Hospital preserved it from the taint of charity. He who freely gives is a more ardent supporter than he who pays rates.

Finance.—The question of the relationship of one type of Hospital to the other comes into prominence primarily by means of a constant indebtedness to the bank, necessitating appeal, and a constant waiting list on the part of the Voluntary Hospital. These difficulties do not concern the Hospital provided by the Local Authority. Its purse is the Poor Rate. Its size is determined by the demand upon its resources.

No Voluntary Hospital is so well supplied with funds that no matter how it extends its sphere of usefulness it is never in debt. An annual excess of expenditure over income is thought by some to indicate extravagance. That is theory. Practically it shows a forward policy, a vigorous life, a commendable attempt to undertake more work for the public good than its means will allow.

Efficiency.—The co-ordination rumour persists in spite of repeated assurances to the contrary by successive Ministers of Health. Someone devoid of the sense of humour has given it as his considered

opinion, that if and when the State decides to take over the Voluntary Hospitals, their " waiting lists " will be the determining factor.

It is a curious mind that conceives the idea of closing either a theatre because it constantly displays " House Full " : or the M.C.C., for membership of which you enter your boy at birth : or the Public School without a vacancy for several terms. There is something seriously amiss with the Voluntary Hospital which has not a waiting list : either the reputation of its Honorary Staff is not what it should be ; or its administration is at fault. A waiting list, in short, is a symptom of popularity.

It is a fallacy, however, to lay *too* much stress on the " waiting list." Cases of life and death will always receive swift attention, but a careful analysis will show that a small percentage only of the cases thereon will suffer any hardship or serious inconvenience by waiting six months for an operation to remedy some defect. From the surgeon's point of view, the description of " beauty-parlour " is an apt cachet for this class of operation, though doubtless this is not the point of view of the patient.

Conclusion.—Presuming that the circumstances as stated are in the main correct, it would appear that there is a need for two distinct types of General Hospital—the Voluntary, and that provided by the Local Authority. The one founded and maintained by individual effort : the other provided from the rates.

The one having an Out-patients' Department acting as a free consultative centre to which the general practitioner may refer the poorer of his patients for a second opinion, and selecting its In-patients : the other dealing with general illness in the bulk.

The Voluntary Hospital, already in relationship, co-operation and co-ordination with the University, is educating medical students : is inspiring and directing research, providing the material and means : is teaching and training nurses, and maintaining as a living stream the spirit of public benevolence.

The Voluntary Hospital is hampered in its progress by reason of its inability to increase its capital by quicker means than those of appeal. Although, be it noted, appeals educate the public and quicken the sense of responsibility. If the country is seriously anxious for the health of the people, and, desirous of retaining the Voluntary Principle, urges the immediate expansion of its Voluntary Hospitals, let it show its faith in them by sanctioning the loan of money free of interest for capital purposes repayable over a period of years : by making an education grant for the teaching of nurses : by encouraging support by individuals, by exempting from income tax all gifts for capital purposes, and all legacies from duty.

To sum up, faith in the Voluntary Hospital will solve the problem of finance and demonstrate its efficiency.

FRANK G. HAZELL,
General Superintendent and Secretary,
Manchester Royal Infirmary.

5.

The relations between the Voluntary Hospitals and the institutions managed and financed by public authorities are comparatively simple in country areas, because the former carry out practically all the active and more difficult surgical and medical work. In the wide country area covered by the Radcliffe Infirmary no public authority has, so far as I am aware, made any attempt to equip a hospital capable of dealing with major surgical operations or the more acute forms of disease. It is taken for granted that such work will go to the Voluntary Hospitals. On the other hand, the development of Hospital work by public authorities by making a greater use of the existing beds in Poor Law Infirmaries is made particularly difficult because of the method of access to them and also because of the intense traditional feeling against entering these institutions.

A solution of the problem, and one which has already been followed to a considerable extent, appears to be that the Public Authorities should contract with the Committees of the Voluntary

Hospitals to carry out certain kinds of work for an agreed sum of money, preferably given by means of block grants. This plan avoids wasteful competition and the duplication of elaborate apparatus, and maintains the position of the Voluntary Hospitals in the eyes of the public as the main defences of the country in the fight against disease. At the same time it is most economical from the point of view of the Public Authorities, who could not possibly provide an equally good service at the same cost, and it brings in a regular income to the Hospitals which would in any case do much of the work.

By such means the Oxford City Council and the Oxfordshire County Council and in a lesser degree the Berkshire County Council have contributed towards the cost of the Maternity and Child Welfare Work carried out by the Radcliffe Infirmary. The result is admirable, as the Committee of the latter have been enabled to maintain a Maternity Department in close touch with Voluntary Infant Welfare Associations and with the Public Health Authorities, the work being completed by the holding of a Babies' Clinic in the main Hospital. The result of this combination of forces has been a marked reduction in the infant mortality rate of the City. The City Authorities contribute £1,000 per annum towards the work, and it is unthinkable that for such a sum they could themselves provide so complete a system of treatment for the mothers and babies for whose health they are responsible.

Again, with a view to providing the best possible treatment for tuberculosis locally, and in the hope of eventually making a contribution towards the more successful treatment of the disease, the Committee of the Hospital have recently opened a Sanatorium, about one-third of the capital cost having been provided by the Ministry of Health. The City and County Councils have taken the whole of the beds, for which they pay a maintenance rate, while the management of the Institution is entirely in the hands of the Radcliffe Infirmary.

From the above two examples it will be seen that close co-operation with Public Health Authorities is not only possible but is actually in existence.

To turn to the particular points suggested for discussion.

1. In country districts the Voluntary Hospitals are, generally speaking, the only institutions equipped with scientific apparatus, such a X-ray plants, pathological laboratories; moreover their beds are staffed to deal with cases in which active treatment is required. It would seem, therefore, that they should deal with all cases in which such active treatment is desirable, while all chronic and incurable cases should be passed on to the Public Health Authorities. The latter would then be relieved of the expense of building and equipping modern hospitals which they do not at present possess, and the former would be able to make the best use possible of their highly developed equipment and skilled staffs.
2. Hitherto in this district the Voluntary Hospitals have been able to cope with all the cases requiring elaborate treatment, and as stated above, have undertaken with the help of the local authorities certain forms of treatment for which the latter are definitely responsible.
3. If the respective functions suggested above were adhered to, there could be no question of competition or of less support for the Voluntary Hospitals, for the Public Authorities would not be offering the same services to the public.
4. It is suggested that the more difficult forms of treatment for which the Public Health Authorities are responsible, could economically and with increased efficiency be grafted on to the existing Voluntary Hospitals, whose equipment and experience make them more competent to deal with them, and that the Hospitals should be subsidised for such work out of public funds. The Public Authorities should themselves equip and maintain Hospitals for chronic and incurable cases. It should be made quite clear that the form of a patient's physical disability should decide which class of Hospital he should enter, and not simply his financial position.

A. G. E. SANCTUARY,
Administrator,
Radcliffe Infirmary, Oxford.

Why should there be any competition between the Municipality and the Voluntary Hospital ?

The only reason appears to be the inability of the Voluntary Hospital to cope with the needs of the district in which it is situated, caused through lack of support and the indifference of the populace in the town or county in which it is situated, who should, for its own benefit, see that its Hospital is in a position to meet all demands made upon it.

Not one of the thousands within the district the Hospital serves knows when he or she may need urgent Hospital treatment, but they do little, if anything, to see that the Hospital is so financially sound as to be in a position to have sufficient beds and perfect equipment to admit them in their hour of need. When that hour arrives and they are told that owing to lack of beds they will have to wait, they and their friends blame the Hospital authorities for not being ready for them. If they were advised to go to the Municipal Hospital not one in a hundred would agree to do so.

This is the crux of the whole question and the position appears to be :—

1. The Voluntary Hospitals have not sufficient beds or income to meet the demands made upon them.
2. The Municipality has a number of beds and unlimited income to meet any demands should the occasion arise.
3. The general public will not support the Voluntary Hospitals as they should be supported, and refuse to be treated in a Municipal Hospital unless they are forced.

There cannot be any question but that the last word will be with the public and until they can be induced to make use of the Municipal Hospitals, the Voluntary Hospitals must continue.

Instead of the Municipality spending the ratepayers' money on their own Hospitals, which the public refuse to use, why cannot they bring the Voluntary Hospitals up to a standard of size and efficiency necessary for the needs of the district in which they are situated ?

Everyone must agree that the Voluntary Hospitals are making a splendid fight for their existence, and to scrap such Institutions seems to be a very short sighted policy.

Generally, what is at the back of it all ? The idea appears to be that the Ministry of Health is anxious to have full and absolute control over the whole Medical Service of the country, and that the Medical Officers of Health in each town or county should have bureaucratic control of all Hospitals and Institutions of a similar nature in their respective areas.

Is this idea the best for the nation or the patients ? and this surely should be the first thought of those who are desirous of starting Municipal Hospitals in competition with the Voluntary Hospitals.

So far as the nation is concerned, can the Municipal Hospitals state the actual cost per occupied bed per annum at which they are able to run their Hospitals, including all charges, based on similar lines to the Voluntary Hospitals cost per bed ? If so, what is the difference in cost, if any ? This is what the public should be told. Providing all things are equal, and they can honestly state that they are able to run their Hospitals as economically as the Voluntary Hospitals, then the nation can have little to say on the question of expense.

What about the patients ? The Municipal Hospital is under medical authority—the patient is a case and is treated as such—the treatment becomes a business pure and simple, and the older these Hospitals become the greater will this attitude develop.

In the Voluntary Hospitals under a lay board of ladies and gentlemen with a lay Secretary or Superintendent, the patients and their friends receive the sympathy and kindliness of feeling which materially helps them in the changed life from home to Hospital. Complaints, legitimate and otherwise, are made direct to the Secretary who, on obtaining facts, lays the same before his board, who give it sympathetic and careful attention. Whoever is to blame is dealt with accordingly, be it doctors,

nurses or other officials. Under a Municipal Hospital ruled from top to bottom by a bureaucratic system, one wonders where the poor patient would come in, he or she would be the last person to have a say in the matter.

With all due respect, the education authority might be taken as an example of State control. Before schools became municipalised, there were schools up and down the country which existed on results, the better the education they gave the more pupils they got, competition was keen, and therefore efficiency greater than it is to-day. To-day we spend millions a year on education, and the results do not appear in any way to justify so large an expenditure of public funds.

Voluntary Hospitals as run at present are keen to be efficient and to be appreciated by their patients, and through them by the public at large. They strive for the goodwill of the public they serve, and though money to-day is scarce and funds difficult to obtain, the patients attending the Voluntary Hospitals and their friends are as generous as their incomes will allow.

In my opinion the best way and the only way is for the local authorities to develop their Hospital service in co-operation with the Voluntary Hospitals, starting off with what is already in existence and what the public appreciate and patronise : the foundations of a sound medical service are already here in our midst, why not make the best of them, improve them, scrap what is bad in them, retain what is good, and let us all work with one aim to give the best that medical and surgical science can give, plus the human element, for our sick brothers and sisters in their hour of need. Everyone, rich or poor, should have the same opportunity of that greatest of all good things, " Health," and opposition, self-aggrandisement, bureaucracy and everything that tends to prevent this becoming practical should be swept away.

It appears to me that with goodwill and one object in view, it should be possible for a " scheme of " whole-hearted co-operation to be devised which would preserve the character of the Voluntary " Hospitals, maintain its support, and graft on to the State Institutions all those desirable qualities " that the British Voluntary Hospitals stand for." The Voluntary Hospitals have, as their assets, the goodwill of the public, medical and surgical staffs of the highest, certain invested funds and up-to-date equipment. The Municipality has on its side the power to tax the public to carry on the work at present done by the Voluntary Hospitals.

On what lines could this arrangement be carried out and to what extent should grants be made to Voluntary Hospitals out of the rates ?

1. Patients whose total income did not exceed, say £500 per annum, would be classed as Hospital patients. In the case of children whose parents' total income did not exceed £500 per annum, they also would be classed as Hospital patients. When the total income was above £250 (the amount which exempts from the National Health Insurance) such patients would have to pay the full cost of hospital treatment, worked on the basis of the cost per bed and cost per out-patient of the preceding year. N.B.—The foregoing incomes could be properly considered. They may be at too high a scale.
2. The patients who are under the National Health Insurance would be paid for by the National Health Insurance Commissioners on the same terms as those mentioned in number 1. This might necessitate an increase in the present rate of contribution, but as many of these are also at present contributing to a Hospital Fund, the money at present paid to such a fund could be added to the State Insurance, an addition of 1d. and 2d. per week. This would bring all workers into line.
3. Those patients who do not come under numbers 1 and 2 are surely patients for whom the State should be responsible, and their names and addresses should be sent to a Municipal Almoner or Relieving Officer to enquire into their circumstances, and they would be charged up with as much as it was considered they could afford to pay—the balance being made up out of the poor rate.
4. Should the patients in number 1 refuse to pay, the amount owing should be recoverable by law. Whether by the Municipality or by the Hospital, could be decided by arrangement.

5. Patients sent to Hospital by the Education, Tuberculosis and other Government Departments should be paid for in full by such authority.

6. Patients whose income exceeds £500, but under say £1,000, should be allowed the use of hospital private wards, and the physician or surgeon attending the patient would be allowed to make a charge for his services.

7. All the honorary staff (medical, surgical, and special) attached to Hospitals should be paid a retaining fee, and would thus become paid servants of their respective Hospitals, and a limitation should be imposed on the number of appointments held, in order to ensure service.

The voluntary principle should at all costs still be maintained, and each patient should have a " free choice " to go to any hospital he or she desired. Otherwise what does the term voluntary signify to-day.

The foregoing suggestions would wipe out all contributions except that of payments for actual work done, and this would bring home to the patients their individual responsibility.

Income from investments could be dealt with in (*a*) either reducing the cost per patient, or (*b*) by using such funds for making up any losses which might occur, for research or special work which could not be made chargeable to the patient or those responsible for such patient or for extension and alterations to buildings and equipments. This question could be reviewed from time to time in the light of experience.

The Committee of Management or Board of Control should consist of not more than 20 in number, and be divided between influential ladies and gentlemen of the town or county, representatives of the Health Department, the Medical Officer of Health, and representatives of the classes from which the patients come in category 1.

It does not appear to me that it is a fair proposition to expect the comparatively few generous hearted and sympathetic public to continue to have to find the money for the treatment of patients, who, if they cannot afford to pay for themselves, should be paid for by the State.

Then there arises the question of who is to pay for patients admitted as the result of a street accident or who come under the Employers' Liability Insurance. In both cases they would come under category 1 or 2. Those whose income brought them under No. 1 would reclaim the cost of their hospital treatment from the person or Insurance Co. who was responsible or liable for such payment. Those who come under category No. 2 should still be paid for by the National Health Insurance Commissioners who would reclaim on the Insurance Co. concerned for a refund or on the individual if it was a street accident. Those in category 3 would be charged to the Guardians who would also endeavour to reclaim.

I do not think it at all likely that if the Municipality extended its Hospitals, they would receive the support of the public or that the public would make use of them to any extent. Neither do I think that the Voluntary Hospitals need be afraid of any opposition in this direction.

Wrecking the present system would be criminally wasteful, but to build a perfect Hospital system on the foundations already laid would be the wisest and soundest statesmanship and a credit to the country.

The present situation is one in which the decision which will be arrived at will be the result of the conflict of the two views of thought, viz., whether to continue under a free individualistic line of development or under a bureaucratic system. The whole trend of modern thought is now setting definitely against a further extension of the pretensions of bureaucracy. Furthermore, the best type of medical man will never be found within the confines of a bureaucracy, since the best type is essentially individualistic.

HERBERT J. DAFFORNE,
General Superintendent and Secretary,
Ancoats Hospital, Manchester.

That there is considerable overlapping in the general health services of the country is well known to all concerned in public health administration, and there is no doubt that a great deal can be said for some whole-hearted and comprehensive scheme of co-ordination. On the one hand we have the Municipal Hospitals, Dispensaries, School Clinics, Maternity Homes, Child Welfare Centres, Sanatoria, Mental Hospitals and Poor Law Infirmaries, whilst on the other we have the Voluntary Hospitals, both general and special. It is becoming increasingly difficult for these latter Institutions to pay their way and the free gifts of the charitable public are no longer sufficient to maintain them. This discrepancy can be traced to two causes—the rapid strides made in medical and surgical science have made the Hospitals much more technical and highly specialised Institutions, with the result that the cost of maintaining them has considerably increased, also whereas Hospitals were, at one time, only used by the indigent poor, they now serve a much larger class—indeed, it is doubtful whether those for whom they were created now constitute more than 10% of the cases dealt with.

Whilst the Voluntary Hospital system has done wonderful work in the past and well deserves the high place it has won in the esteem of the nation, it cannot for these reasons be expected to enjoy a state of immunity and must be judged by present day results. We must ask ourselves whether the Voluntary Hospitals are adequate to meet the demands made upon them ? The answer to this question is provided by the long list of persons awaiting admission and to the report of the Voluntary Hospitals' Commission, which states that 10,000 additional beds are required to meet the present needs. The question then arises whether the Voluntary System can provide these beds and their maintenance. This seems to be answered by the fact that in spite of frequent extensions, the work of the Hospitals is being largely supplemented by the Public Institutions and Clinics already referred to, and it is to be feared that they cannot hope to cope satisfactorily with the ever increasing demands for hospital treatment.

An efficient health service is a first essential to any well organised community—and no system or group of systems can be regarded as satisfactory unless they are adequate to meet the needs of the times. There can be no doubt that, at present, we fall short of this standard and that considerable development is necessary if proper hospital services are to be made available for all who need them. If this be so, the deficiency must be made good by the State or Municipality. The difficulty is to see how in any co-ordinated scheme of health services, the voluntary system can be retained in its present form. The establishment of municipal hospitals, if efficiently staffed and free from the stigma of the poor law, must, in time, adversely affect the voluntary hospitals, and the tendency will be for these latter institutions to become simply glorified nursing homes or provident institutions, used mainly by those who are not prepared to go into the public hospitals. As the public hospitals progress and develop, and so obtain the confidence of the public, the demand for treatment in the voluntary hospitals will diminish. If the voluntary system is to be saved, we must realize its deficiences and be prepared to sacrifice its present isolated position to a more closely united co-operation with the public authorities and by a willingness to fulfil those functions for which in a co-ordinated health scheme, it is considered to be best fitted.

Complete co-ordination can never be obtained by several units acting in watertight compartments, and if the present overlapping and duplication is to be avoided, the establishment of some central control appears to be the only solution. Health Committees, representative of all interests concerned, might be set up in different areas, whose duty it would be to prepare a co-ordinated scheme of health service, and to guide health policy. Such committees would be also responsible for deciding how the available hospital beds in the area could be most economically administered and best utilised. They would decide what additional beds were necessary, and when and where they should be provided. All extension schemes would be submitted to these committees for approval or otherwise—and as far as the voluntary hospitals are concerned, grants in aid of maintenance or towards such schemes should be controlled by them. A scheme of this kind would ensure a complete and comprehensive health service : the voluntary hospitals would not lose their identity, and apart from a certain amount of beneficent control from the central committee, would continue to function, and be managed, as at present.

The public would have the satisfaction of knowing that their money was being wisely spent and

that spirit of warm-heartedness, sympathy, and charity, which has always animated the people of our race—and which is peculiar to the voluntary hospital system, would be retained. If this is to be accomplished, some solution along the lines indicated, seems to be not only desirable, but necessary.

S. C. FRYERS,
House Governor and Secretary,
The Royal Infirmary, Sunderland.

8.

I wonder how long we have talked of co-operation with the Poor Law Infirmary ?

Years ago the waiting lists of our Hospitals compelled us to think and talk of such a possibility. Is there the same need for such co-operation to-day ? Are our waiting lists shorter ones ? The number of accidents on the streets these days is simply appalling ; admission to Hospital follows, the beds thus occupied are not available for cases that otherwise would be admitted, and so the waiting list grows. It seems therefore, as though in the near future in all the large industrial areas, the much talked of co-operation must become an accomplished fact if the people are to receive the attention they need.

I should like to see the Infirmary in these large centres working " hand in glove " with the Voluntary Hospital, taking perhaps cases requiring prolonged treatment and so releasing much needed beds in the Voluntary Institution. I see no insurmountable obstacle in the vital question of staffing. Why should they not be staffed by the Physicians and Surgeons of our Voluntary Hospital on a part time basis ? Of course, they would have to be paid, but given the spirit of " Locarno " and ever keeping before one the needs of the people who require " Repairing " ; remembering too the enormous economic waste to both the individual and the community from the enforced idleness of the prospective patient, it should be, nay is, possible to have such an arrangement.

This is not the place to discuss the question of finance or the suggestion of part time service of medical men, it is I think sufficient to say that if the Infirmary is to be as popular with its patients as the Voluntary Hospital is with its patients, then the staff of the one must at least be equal to the staff of the other. It is, to say the least, a shame that so many people should be waiting for beds in the Voluntary Hospital when so many beds are vacant in the well built and well equipped wards of Poor Law Institutions.

Let us then do our best to hasten the time when this kind of thing will be but a memory.

W. H. HARPER,
House Governor and Secretary,
Wolverhampton and Staffordshire Hospital.

9.

The relationship of the Voluntary Hospital to the Hospital provided by the Local Authority and the desirability of co-operation has been referred to on several occasions by the present Minister of Health, and although probably few of the managing bodies of Voluntary Hospitals have yet given much consideration to the question, it is recognised that here is a problem which will require much thought in the near future. Although there is a general tendency for Local Authorities to develop their Hospital Service, in some areas very little has been done in this direction, whilst in others the Local Authority Institutions are duplicating the services of the Voluntary Hospitals.

We must assume that a general and uniform development of the Local Authority Hospital Service will gradually take place, and it is highly desirable that this should follow in co-operation with the Voluntary Hospitals. The possibilities of an economy in the expenditure of public money must surely compel the Minister of Health to insist that no general development of Local Authority Hospital services takes place without endeavouring to co-operate with the Voluntary Hospitals.

It may also be assumed that the Voluntary Hospitals will be prepared to co-ordinate, but there are difficulties in approaching this matter at present, in view of the fact that the Public Institutions in an area are not under the control of one particular body. In one borough alone you have a

Sanatorium managed by a County Health Authority, a Maternity Hospital by the Borough Council, and an Infirmary by the Board of Guardians.

With this position of affairs altered by the institution by the Ministry of Health of a Central Health Authority, an attempt at co-ordination could be made by defining categories of cases which could be allocated to the Voluntary Hospital or the Public Institution. In many areas to-day an effort is made to work on these lines, but there is no agreed plan, and the allocation of certain classes of cases only operates to a very limited extent, hence the not uncommon experience of empty beds in the Public Hospital and a full house, with a large " waiting list," at the adjacent Voluntary Hospital.

The classes of cases which the Public Hospital could take might include many of the simple medical and surgical cases which the Voluntary Hospital accommodates at the present time, in addition to the incurables, chronics, and those whose home conditions render treatment in an Institution desirable.

The Voluntary Hospital, thus relieved of a certain portion of its present work, could be used to its fullest extent for the purpose of dealing with the more serious cases, which it is generally conceded, it is well able to do. It is possible that with such a system of co-operation, very little further extension of Voluntary Hospital accommodation might be needed, and a saving in this direction could be utilised for improvements and adding to the efficiency of the existing service. There are many channels in which co-operation between the Voluntary and the Local Authority Hospital could be advanced, and I think a start in the direction indicated above would lead to a scheme whereby an economical hospital service would be available for the benefit of the community.

With a clearly defined plan of activity, there can be little doubt as to the Voluntary Hospital receiving sufficient support for its maintenance. If no plan of co-ordination with the Local Authorities is arrived at, and the Voluntary Hospital has to be further extended at periodical intervals—providing services which are already at the disposal of the public at the Local Authority Institution—then it is questionable whether the Voluntary Hospital could provide the necessary funds to meet its needs. Co-operation must mean a general economy and the transference to the Local Authority of a certain proportion of the present expenditure borne by the Voluntary Hospital.

The question of the development of the Local Authority Hospital service and the possibilities of co-operation have not been considered by the Board of Management of this Hospital so that the above must be taken as my personal views on the matter.

FRANK INCH,
House Governor and Secretary,
Norfolk and Norwich Hospital.

10.

The generally accepted idea is that the sick who are unable to receive proper nursing at home are admitted to the Poor Law Hospital.

Sir Arthur Stanley foreshadows that the Poor Law Hospital will develop and take " not merely " chronics and incurables, but all simple medical and surgical cases which the domestic circumstances " of the patient might render unsuitable for treatment at home."

The Voluntary Hospitals have become the centres of specialised treatment of acute disease, the training of doctors and nurses, and research.

Here are two spheres of activity which make classification possible.

Where should the many developments of the Local Authority Public Health Service be centred ? Sir Arthur Stanley's idea is that " all clinics and treatment centres under the public services should be " associated with Voluntary Hospitals." Leaving this question open, the specialised treatment of all disease outside these developments is the province of the Voluntary Hospitals, a province which is rapidly coming to include all classes in the community.

Given adequate accommodation on both sides, three conditions only are needed for co-operation

and co-ordination :—(1) The removal of the prejudice against the " Poor Law " ; (2) The simplification of the admission of patients to the Local Authority Hospital by altering the settlement laws and making a patient's residence at the time of application, or his residence in a Voluntary Hospital, the qualification for admission ; (3) Good-will. These conditions can surely be fulfilled and realised.

It is suggested that a " clearing house " system would be needed to distribute patients to the various institutions. Would this additional organisation be necessary ? A Voluntary Hospital receives an application from a patient, and the Staff are of the opinion that the patient should be admitted to the Local Authority Hospital. Surely the two Institutions can agree, given good-will, to which of them the patient belongs ? It is frequently said that beds are empty in one Voluntary Hospital while another has a waiting admission list. Should not this question be dealt with by the Voluntary Hospitals themselves ? A new organisation does not necessarily solve a problem. A Clearing House with presumably autocratic powers might easily create new problems.

In some areas, of course, the Local Authority Hospital needs to be brought up-to-date. In some areas, again, the Local Authorities have set up fully equipped General Hospitals. From the Voluntary Hospital point of view it is a thousand pities that Voluntary Hospitals have not kept pace with the demands for General Hospital treatment. Taking the position as it stands, the logical policy where Contributory Schemes operate is for the Contributory Scheme Funds to pay to the Local Authority Hospital the actual cost of maintenance. The Hospital Savings Association have adopted a variation of this policy by negotiating with Metropolitan Boards of Guardians with the view to the adoption of a uniform standard rate of payment to Guardians direct, which would, on the average, be equivalent to the amounts which the Guardians might reasonably expect to receive from the patients or those chargeable on their account. The former may seem an extraordinary suggestion, but, in every case, and not only where Contributory Schemes or the Hospital Savings Association are adopted, contributors to the Voluntary Hospitals naturally expect to be treated in the Voluntary Hospitals when suitable, and subscribers share the expectation. It is difficult to believe that a dual system of General Hospital treatment can be permanent. The tendency surely will be for the charitable public gradually to allow the Local Authority to relieve them of their voluntary obligation to maintain their General Hospital. It may be possible to stabilise a dual system, but it will not be easy.

The better way is for the accommodation to be provided at the Voluntary Hospitals. Can the Voluntary Hospitals provide the needed beds ? The War arrested development, and the road accident cases have made new demands. Voluntary Hospitals can find new annual income by wise publicity and sincere appeal ; to raise capital sums is more difficult. Would the Government revive the recommendation of the Voluntary Hospitals' Commission to secure a grant for Hospital accommodation ? Again, is it unsound finance to submit that accommodation for road accidents should be supplied from the fund created by the class which supplies the great majority of such accidents, in other words, by grants from the Road Fund ? If no grant is possible, the Voluntary Hospitals must rise to the occasion if the Voluntary Hospital System is to be maintained. If either or both of the foregoing proposals could be accepted, the outlook would be hopeful.

A co-ordinated Public Health Service dealing with co-ordinated Voluntary Hospitals is the immediate need. For any payment to Voluntary Hospitals for work done, the test which the Local Authority would apply is the test which it applies to a contractor, namely, can he " deliver the goods ? " Representation on the Voluntary Hospitals Management would of course be granted.

It is acknowledged that a co-ordinated Public Health Service is needed. It is less clearly realised by the Voluntary Hospitals that they also need co-ordination. The Voluntary Hospitals urgently need one central representative body, efficient, well-informed, able to think through the problems of the day and present results to the Hospitals ; to formulate a policy and give a lead. There is urgent need of a common policy and co-operative action, and for the various organisations at present working independently to be unified. There is no other way. Local or Regional action is not enough. And the time to organise is the present.

J. ROWSE MITCHELL,
Secretary,
Royal Infirmary, Chester.

11.

The Voluntary Hospital in England, begun as an expression of piety or philanthropy, has, during the course of many decades developed into the embodiment of a great tradition ; a tradition of ministration to the sick poor, of medical service, and of education, which has grown into the national life without the community as a whole realizing its existence or appreciating its functions. During the greater part of the time each Hospital has been governed by local influences, and supported financially by the area which is served. In early days those who came in contact with the Hospital at all were sharply divided into two classes : (*a*) Those who gave to its support, and (*b*) Those who received its benefits. Those who gave did so for the benefit of others, and the patients were the indigent sick.

The development of industry, the increased use of machinery, quick motor transport, the Great War, the consequent alterations in the social life of the people, and the altered value of money have all affected the position of the Voluntary Hospital. The numerous casualties of industry have required an extended service for which the Hospitals are but partially recouped by contributory schemes (where they exist). Quick motor transport, whilst filling beds with an increasingly large number of patients, has eliminated the necessity for the existence of a large number of Cottage Hospitals. A considerable body of medical men are of opinion that their profession is being exploited, to some extent, by the treatment at the Hospital of patients whose means would normally allow them to pay for professional services, and the Hospital treats a very considerable number of patients, free, whose treatment is supposedly provided for out of public funds, but is never paid for.

Contributory schemes have further complicated the issue by setting up what is practically a network of insurance schemes.

The Hospitals themselves have lost a great deal of their isolation and are shewing a greater desire to co-operate among themselves than heretofore.

Developing slowly and along different lines, during the latter part of the same period, the Public Health Services to-day are represented by a Ministry of Health, a National Health Insurance Scheme, Municipal Hospitals, and generally a medical supervision of the individual from the Welfare Centre, through school medical inspections, factory supervision, etc., to a pensionable old age, yet the medical needs of a large portion of the population are still unprovided for by the State.

Whilst the Public Health Services have always necessarily developed along the lines of *authority*, the Voluntary Hospital has grown great as a philanthropy. The objects of both are to some extent the same, but their motives, methods and expression are very dissimilar. It is far more difficult to visualise a public Hospital being conducted with the traditional Voluntary Hospital spirit, than to see Voluntary Hospitals absorbed entirely in a national scheme. Although there are quite a number of instances of co-operation between Local Authorities and the governing bodies of Hospitals, there are no apparent signs of a general co-operation. A number of Local Authorities are developing their public health services quite independently of the local Hospitals, and in some cases in open opposition to them.

Hospital Authorities, when asked to undertake work for public authorities are generally very willing to be as helpful as possible, but they cannot be expected to do anything for the State, or any outside body, for less than its cost. It is hardly fair to make a gift to the State out of the income from funds held in trust for the benefit of the sick poor. Further, as no section of the public should be required to render the State a free service for which all are not liable, the cost of work done for Public Bodies should include a suitable remuneration for the services of the Hospitals Medical Staff. In any National Scheme this remuneration would have to be adequate for the service rendered, not merely a small percentage in recognition of a principle.

The Voluntary Hospitals, certainly in this area, and presumably elsewhere, have been able to obtain the funds necessary for the development of their activities.

There would not appear much doubt that the development of the Local Authority Hospital would in time reduce the support of the Voluntary Hospital.

It would appear, therefore, that if the Voluntary Hospitals are to take their proper place in a national public health service, it would be to the interest of the State to use them to the fullest extent, and to allow such departments as they wish set up to be administered with all the elasticity characteristic of a Voluntary Hospital, but the difficulties that present themselves are :—

1. The rigid adherence to regulations necessary by all public administrative departments, which would render difficult co-operation with the voluntary government so elastic as that of a Hospital.

2. The adequate payment for services rendered by a Medical Staff wishing to retain, and in some cases compelled by the Hospital rules to maintain, its honorary status.

3. The strong feeling against State interference in the internal administration of a Hospital.

4. The absence of security that the Hospital would be able to obtain equitable payment for the cost of its services.

5. The disinclination of patients to attend a State or rate aided Hospital when a Voluntary Hospital is available.

These difficulties are not insuperable. They could be overcome by good will, and a real desire on both sides to be mutually helpful.

The Hospitals to-day are in a much better financial position than they were even a few years ago. Their invested funds, the generous support by the public, and the services they are able to render place them in a position to negotiate with the Government for their rightful place in a National Scheme of public health, but they are at the great disadvantage that they might have to deal with a Minister of Health unsympathetic to their aims, and determined on a scheme of his own.

To leave the Hospitals out of the Scheme would be extremely wasteful from the National point of view. It would also leave the Hospitals isolated from the bulk of their patients with a consequent loss of public support.

Some scheme of co-operation and co-ordination is assuredly advisable in the interests of both the State and the Hospitals. It should not be a very difficult task to weld the two systems into a united service in which the distinctive policy of each could be retained.

H. ST. JOHN WOOD,
Secretary-Superintendent,
Northampton General Hospital.

THE IMPORTANCE OF THE ALMONER'S DEPARTMENT IN THE HOSPITAL.

An Address delivered by

SIR BERKELEY MOYNIHAN, K.C.M.G., C.B.

President of the Royal College of Surgeons,

At a Meeting held by The Institute of Hospital Almoners, May 26th, 1927.

If you make a brief survey of the social history of this country you will find, I think, that of all the benefits conferred upon his fellow men by the pious benefactor, there are none of quite the same value as those which have been expressed in times gone by, and are still being expressed by gifts to our hospitals. The hospitals have played perhaps a greater part in establishing and securing the welfare of mankind than any other institutions in our history. The three medical men who stand supreme, Harvey, Hunter and Lister, have certainly contributed more to the advancement of human happiness, and mankind's material welfare than any other three men who ever lived.

The hospitals began as almshouses and only gradually drifted into the position of being institutions also for research. The work done in them, if only scientific is incomplete. We, of almost a generation ago, were, I think, quick to realise that, whatever our efforts might be in the conservation of a limb, the restoration of health, or the repairing of some mechanical defect or deformity, there remained something over and above all this which was necessary to carry out functions to their fullest fruition. The work of the hospitals is not concerned merely with the momentary restoration of health in an individual suffering from particular disease. The business of the medical practitioner, in whatever sphere of work, is to restore the units of the industrial army to perfect efficiency and to keep them in the ranks. We who watch cases over a period of years soon realised that, however brilliant might be the success of our efforts when the immediate result was examined, a good deal remained to be desired when the ultimate outcome was studied.

Take, for example, an individual whom I have seen within the last 24 hours. I remember him 30 years ago when he came up literally a " measly " child to the hospital with bronchitis, enlarged tonsils and commencing tuberculous glands. He was restored temporarily to health, went out to one of our sunless slums in Leeds, and came back in a year or two with tuberculous glands on both sides of the neck. Those were removed. He came back five years after with tuberculous disease of the hip and was kept under treatment for two years when again he was restored to health. He came in two years after that with the hip broken down and the hip joint was excised rather too late. He came back again later with a multitude of sinuses and had the thigh amputated at the hip joint. This is a series of diseases attacking one individual for one reason, and that was that, although I think the surgical treatment was satisfactory, the After-Care was neglected. That is the kind of case which every surgeon attached to a large hospital can multiply by the score, or even by the hundred, and is a witness, I think you will agree, to the necessity for the most careful After-Care of patients.

We speak often in the wards and out-patients' room of certain things which are required to be done for patients. We say that rest and change are necessary ; that certain apparatus should be applied to the patients in order to fulfil or to replace surgical treatment. We are talking very often a language which patients are either unable to understand, or we are suggesting actions which they are quite incapable of carrying into effect. It is evident that we need, in connection with our work, somebody who shall carry out our suggestions or our instructions until they are made effective. This is tantamount to saying that one of the necessary corollaries or completions of surgical work is social service. Nothing, I think, has more impressed itself on my mind during the last few years since at the Leeds Infirmary we started our system of almoners, where we now have five, than the saving in human life

and the alleviation of human misery through the constant and devoted work which is given to the hospital by the almoners.

But there is an even better use, in my judgment, to which the almoner may be put. It is the case of prevention as against cure. So many of our patients come to the hospital, their lives threatened, who are entirely unfit to undergo the treatment which we are ready to give them—poor, ill-nourished, maimed, warped specimens of humanity whom somebody must get back to life before we can restore them to health. And it is in connection with social service to the poor before medical treatment can be undertaken that the roots of preventive medicine lie. All the forward-looking minds in medicine to-day are engaged in this question of preventive medicine which has its springs in the daily routine of a man's life.

If you really go into the causes of disease so far as you can, and into the social circumstances and environment of patients who come to you with one or other form of disease, it is hardly an exaggeration to say that a multitude of people, possibly even the majority of people, commit suicide. It is possibly, a dramatic way of putting the matter, but I think it is true. Disregard of the ordinary laws of health and ignorance with regard to fundamental facts concerning life's daily routine, are quite enough to allow that slow and insidious decline from health which eventually becomes something which neither a physician nor a surgeon can completely alleviate. All this leads, I think, to the obvious necessity for that social service which is best carried into effect in the hospitals through the almoners.

But the almoner, like the doctor and the nurse—the tripod on which successful treatment stands—must be really competent for her job, and, in order to be competent, she must have certain natural gifts and be specially trained. I can quite well visualize my ideal almoner, just as I dare say you and I can visualise our ideal surgeon. My ideal surgeon is a very handsome man of distinguished presence ; a man of wide knowledge and general culture, of great technical skill and of sound judgment, and a man with a compassionate heart. After hearing that description of the ideal surgeon you may perhaps agree with me that ideals are not so much for capture as for pursuit, and that you are likely to recognise these qualities as necessary in the surgeon but will search the earth in vain to find them in the one individual. So I depict in my own mind the ideal almoner. She should, I think, be a gentlewoman ; a person of good breeding and high character ; she should be in love with her job, trained to her duty by a course which, I admit, is extremely arduous ; she should have a sense of compassion for others but not that kind of sterile pity which hurts even the bestower. We do not want merely affection for her fellow creatures ; we want trained skill in the typical almoner, and I am glad to say that, so far as my experience goes in the North, we are finding exactly the kind of gentlewoman we need, and her efforts are backing up the medical man and those of the nurse. No tribute that I can ever pay will express what I owe in my work to the nurses who help me. The almoner, with them, is the safeguard of the patient, not only in time of illness but in the period through which the relapse to former troubles is very likely. The almoner at her best is really the doctor's ambassador on the domestic hearth.

I said just now that we often speak a language which patients do not understand. I am sure that that is true. We need somebody to carry our message into the homes of the people, to make them realise how our wishes and instructions can be carried out adequately and be made purposeful. But the almoner is more than that. She is the community's ambassador too. The charitable people of this country have established a whole series of institutions and of methods by which the indigent and the suffering can be helped. It is the almoner's business to make herself cognisant of all these institutions, so that she may bring them to bear on the patient after the physician or surgeon has done with him, and make remedial work fully effective.

There is one matter in which I think a great impulse can be given to the work of the almoners at this moment. There has been discussion in Government circles within recent months in reference to the taking over of Poor Law Hospitals by the City Councils, or by other proper bodies. I think the Government might give a lead in this matter, and might make us all realise, that which, in my judgment, is true, that unless every hospital in future has a recognised member of its staff an almoner, or even two or three or four or more, the work which has been done in that hospital is not having its full effect, and that there is in all probability a very heavy waste of money. I have been more

than ever surprised during the last few years with the benefits which result from the collaboration of almoners with our work. I hope I am not saying anything which will wound anyone here when I say that at first I was reluctant to admit the almoner into my counsels. I thought her "fussy" and that she was bothering about things which did not matter. But now I desire most emphatically to say that the work of the almoner is, in my judgment, absolutely essential to the welfare of patients, and that it must in future be considered a discredit to any hospital which does not make use of almoners in its service.

Miss A. E. Cummins, Lady Almoner of St. Thomas's Hospital, London, writes:

A meeting arranged this summer by the Institute of Hospital Almoners brought much encouragement and inspiration to all those who are concerned in the extension of the work of Hospital Social Service. The value of the testimony of the two Presidents of the Royal Colleges as to the need for a Social Service Department as an essential branch of Hospital work, the stress that both these authorities laid on the fact that the "treatment of disease cannot be limited merely to the stay of the patient in the Hospital," and on the necessity for Almoner's work in prevention, after care and even research, cannot be too highly appreciated. Of late years, owing to the heavy financial anxieties that have had to be borne by the Governing Boards of the British Hospitals, it is only natural perhaps, that there has been a tendency to regard the Almoner almost solely as a useful money-raiser and an officer for the prevention of Hospital abuse. While the authorities of a Hospital may see fit to allocate to the Almoner the duty of urging all who are able to do so to take their share in the cost of their treatment, and furthermore, while doing so, to educate Hospital clients and, through them, the public at large as to the value of the Hospital to the community, such duties form only a small part of the Almoner's work. All the evils that beset a patient's mind, body and estate, are the concern of the social worker and it is her task to ensure, in so far as is humanly possible, that no social or economic difficulties shall prevent him or her from benefiting to the full by the skilled care and devotion of doctor and nurse. All agencies for relief, voluntary or municipal, all the resources of educational facilities, health services, national insurances, etc., form her pharmacopœia. While the doctor concentrates all his skill and attention on the patient's body and mind, the Almoner must consider him in relation to the world outside, as a member of a family, a worker in factories, a dweller in tenements, and study the reaction on the patient of all these relationships. This wider outlook was emphasised, and Sir Arthur Stanley endorsed the opinion of the Medical profession at the meeting when he stated: "I do most honestly believe that, if you cut off the work of the Almoners' Department now, from any hospital, you would cut off one of the most valuable parts of the whole service to the community which that hospital is able to render."

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